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ABSTRACT

This guide presents a capacity building framework and process for demonstrating and documenting prevention outcomes. "Achieving Outcomes" was developed by the Center for Substance Abuse Prevention (CSAP) in response to requests from the prevention field for guidance in selecting and implementing science-based prevention programs. The guide is organized conceptually around a framework called a program logic model. The components of the model are the five chapters of the guide: (1) needs and assets assessment, (2) capacity building, (3) program selection, (4) implementation and assessment, and (5) final evaluation. Each chapter is graphically represented as well by a component logic model, or conceptual map, of the activities that make up the chapter. It is hoped that the guide will keep practitioners focused on authentic goals and objectives, enabling them to select an appropriate intervention that--when properly implemented, measured, and evaluated--will lead to behavioral change and, ultimately, substance abuse prevention and/or reduction. This guide seeks to help ensure that what practitioners are doing in the prevention field leads to measurable change for their chosen population, policy, or neighborhood of interest. (Contains 45 references.) (GCP)

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2002 Conference Edition

# Achieving Outcomes: A Practitioner's Guide to Effective Prevention

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# Achieving Outcomes:

## A Practitioner's Guide to Effective Prevention

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# Acknowledgments

This 2002 Conference Edition marks CSAP's commitment to bringing effective prevention to every community across the country.

One of several in a new series of knowledge tools, this Guide for practitioners presents a logical framework and practical process for achieving prevention outcomes. The process includes:

- assessing needs, underlying conditions, and assets;
- building organizational capacity;
- selecting a best-fit science-based program;
- implementing the program(s) using action plans and feedback; and
- evaluating program outcomes along the way.

*Achieving Outcomes! A Practitioner's Guide to Effective Prevention* is grounded in extensive collaboration between CSAP and many of the constituent groups that make up the prevention field. Originated by acknowledged leaders from the evaluation community, then pilot tested with the Drug Free Communities grantees, and made increasingly more customer-driven by representatives of CSAP's Centers for the Application of Prevention Technology (CAPTs) and successive groups of practitioners, this Guide is the product of the two major tenets it encourages—(1) evaluating continuously to create a learning environment and (2) teaming to achieve results.

As CSAP continues to identify and encourage effective prevention programs and practices and to provide capacity building opportunities for States and communities, these knowledge tools will evolve in nature and content. Throughout this evolutionary process, CSAP will collaborate with States, intermediary organizations, and community practitioners to listen and learn about the challenges encountered in moving the field of prevention forward. CSAP is committed to integrating this feedback and developing new guidance to support the field as it continues to grow and advance.

CSAP is proud of our collaboration with the field and the documents that have resulted. We wish to recognize Abe Wandersman, Ph.D., for his seminal contributions on *Getting to Outcomes*, the beginning work. And for her continued leadership and significant contributions to this latest generation Guide—*Achieving Outcomes! A Practitioner's Guide to Effective Prevention*—CSAP wishes to acknowledge Nancy Jacobs, Ph.D., also a senior social scientist affiliated with CSAP's National Center for the Advancement of Prevention (Contract No. 277-99-6023).

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# Foreword

Prevention Works!

You know that. You also know that communities and funders want results. They want outcomes. Moreover, you want to demonstrate that your program works, that the changes taking place are meaningful and do justice to your efforts. The good news is that if you follow the process outlined in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION, you are likely to see measurable outcomes. You will have empirical evidence that what you are doing is accomplishing what you intended.

ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION presents a capacity building framework and process for demonstrating and documenting prevention outcomes. ACHIEVING OUTCOMES was developed by the Center for Substance Abuse Prevention (CSAP) in response to requests from the prevention field for guidance in selecting and implementing science-based prevention programs.

This Guide is the product of extensive collaboration between CSAP and its constituent groups, particularly the Community Anti-Drug Coalitions of America (CADCA), the National Prevention Network (NPN), CSAP's regional Centers for the Application of Prevention Technologies (CAPTs), and the broader evaluation community. Pilot tested with Drug Free Communities grantees and CSAP grantees, the Guide is customer-oriented and responsive to queries and concerns expressed by the field of practitioners seeking demonstrated program effectiveness.

ACHIEVING OUTCOMES presents a capacity building framework and process for demonstrating and documenting prevention outcomes.

ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION can be useful in several ways and at several levels. For the substance abuse prevention practitioner with evaluation experience and a methodical approach to service delivery, the Guide can be used in whole or in part to help you figure out what works or does not work, and why. For those with less evaluation experience, ACHIEVING OUTCOMES will serve best as a conceptual guide enabling you to work comfortably with an evaluator, if one is required, or to provide oversight for an in-house team effort.

Whatever your choice, ACHIEVING OUTCOMES is a process—a way to think about how to make meaningful connections among people, neighborhoods, and interventions. The process is necessarily complex, methodical, and ongoing—from needs and assets assessment to capacity building, from program selection to implementation, final evaluation, and, when called for, back to needs and assets assessment again.

At every point there are procedures for measurement and evaluation. All are linked to one another and linked conceptually to the underlying factors and conditions of the substance abuse behavior that prompted your concern in the first place. Even if the actual measurement and evaluation are beyond your capacity or motivation, a conceptual understanding of the process will help you become a more informed consumer of evaluation services. You will have better control of program direction and ultimate success.

Why is this theory-driven, science-based process so important? A theory-based process, as advocated in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION, will help you or your team figure out what is working and why. It will keep you focused on authentic goals and objectives, enabling you to select an appropriate intervention that—when properly implemented, measured, and evaluated—will lead to behavioral change and, ultimately, substance abuse prevention and/or reduction.

In short, ACHIEVING OUTCOMES will help ensure that what you are doing in the prevention field leads to measurable change for your chosen population, policy, or neighborhood of interest. And if those results are NOT forthcoming, ACHIEVING OUTCOMES will help you find out why not and what steps need to be taken to get back on the right path: the path to prevention.

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ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION is divided into five chapters:

- Needs and Assets Assessment
- Capacity Building
- Program Selection
- Implementation and Assessment
- Final Evaluation

As you move through the process, the most methodical among you will be able to anchor your work conceptually with logic models and document it on action plans. Doing so will help you maintain focus and direction, document outcomes (immediate, intermediate, and final), and make adjustments as needed. Others of you will recognize the methodical thinking behind the logic models and action plans, but will devise your own methods of documenting your work.

Following the ACHIEVING OUTCOMES process is complicated at first. There are procedures within the process—notably needs and assets assessment and the measurement of outcomes—that require specialized training and expertise. For that reason, you may want to seek expert guidance from a knowledgeable and dependable consultant with whom you can work collaboratively to solve problems and improve outcomes.

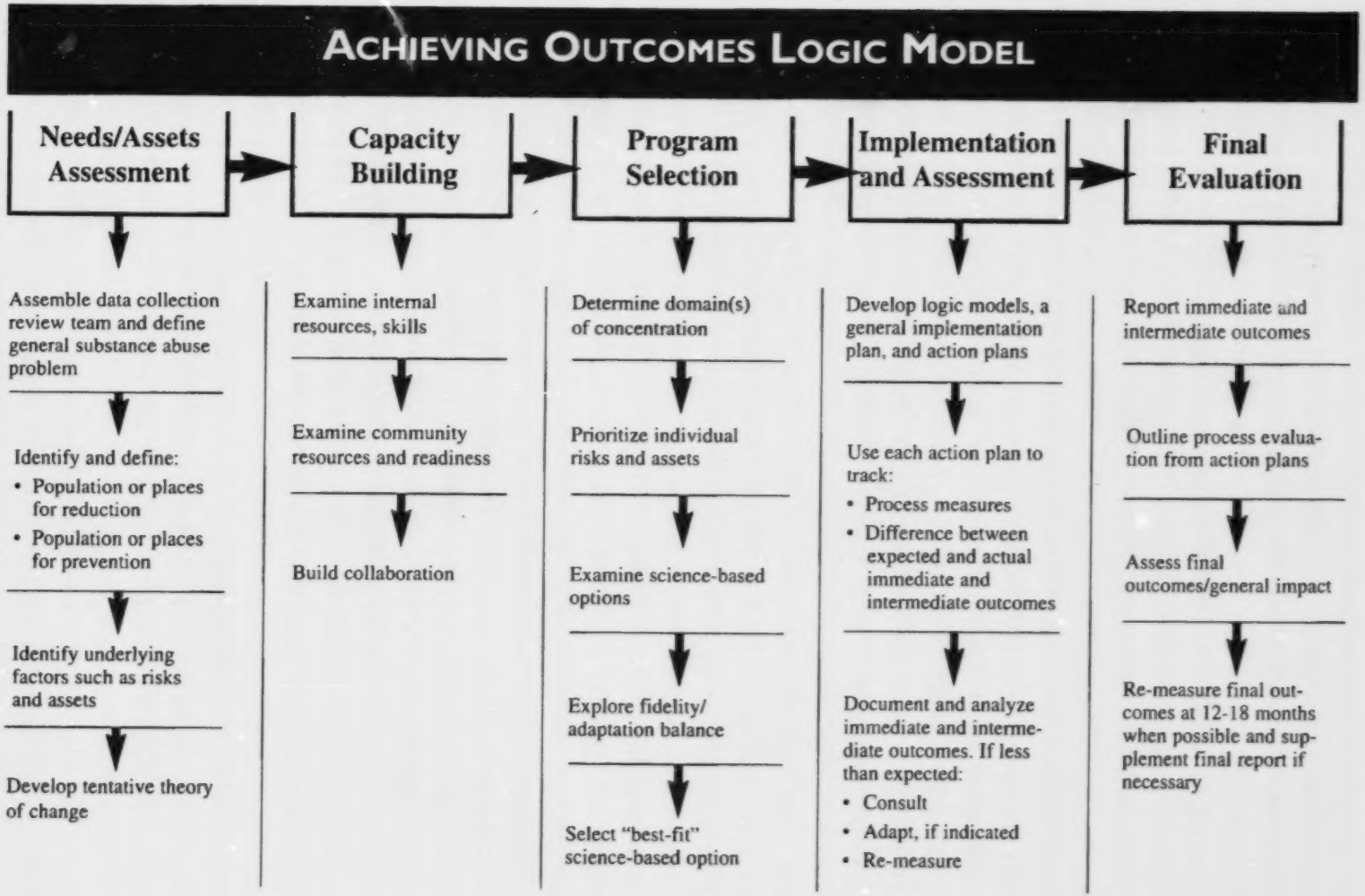
It is not the purpose of this Guide to turn you into an expert evaluator. It is to turn you into an educated consumer so that you can work confidently and comfortably with anyone who can help you to achieve and demonstrate your success.

ACHIEVING OUTCOMES is real help for real people.

It is not the purpose of this Guide to turn you into an expert evaluator.

It is to turn you into an educated consumer so that you can work confidently and comfortably with anyone who can help you to achieve and demonstrate your success.

ACHIEVING OUTCOMES Program Logic Model

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## A Program Logic Model for ACHIEVING OUTCOMES

ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION is organized conceptually around a framework called a *program logic model,* as depicted on the preceding page. The components of the model are the five chapters of the Guide: (1) needs and assets assessment, (2) capacity building, (3) program selection, (4) implementation and assessment, and (5) final evaluation. Each chapter will be graphically represented as well by a *component logic model,* or conceptual map, of the activities that make up the chapter. These are examples of the logic models you will use to organize your own work. You will learn more about logic models and the action plans that support them in chapter 4.

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# Chapter 1

## Determine Prevention Needs and Assets

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# Introduction

Why start with a formal assessment of needs and assets when you may feel you already know what they are? Even if you and other substance abuse prevention practitioners and community specialists have a good understanding of the general substance abuse problem in your community, a formal assessment is essential. You need to take an objective look at the factors and people that are contributing to the problem, not just at the problem itself. This chapter will explain the importance of that assessment and how to go about it.

You will play a key role in developing this needs assessment, along with other team members and, if need be, an evaluator. These types of assessments may be new to you or broader in scope than those you have previously undertaken. This Guide will assist by providing practical information for identifying your defined or "target" population or area of interest and the *underlying factors* that make it vulnerable to substance abuse (*risks*) or resilient to it (*assets*).

Perhaps a *defined population*—even a program—has been pre-determined for you. This defined population may or may not reflect the population you would logically select from comprehensive needs and assets assessment, but it will be the one that the funder or host (e.g., Federal agency, granting authority, school district) is most interested in serving. Reading this chapter will familiarize you with the comprehensive needs and assets assessment process, either to identify the risk and protective factors for this defined population, or to prepare for additional funding opportunities.

Finally, this chapter will outline how you can develop a *theory of change* or, possibly, several theories of change that will inform your selection of an appropriate intervention to reduce or prevent substance use/abuse.

## Needs and Assets Assessment

- Defines the nature and extent of substance abuse problems
- Identifies populations and/or neighborhoods statistically associated with the problem
- Identifies the underlying risk and protective factors of the defined population/group/ neighborhood
- Leads to a plausible theory (or theories) of change that, paired with the appropriate program, should reduce or prevent substance abuse

## Important Terms

*Age of Onset:* In substance abuse prevention, the age of first use.

*Anecdotal Evidence:* Information derived from a subjective report, observation, or example that may or may not be reliable but cannot be considered scientifically valid or representative of a larger group or of conditions in another location.

*Archival Data:* Relative to the collection of data for needs assessment purposes, information that is collected and stored on a periodic basis.

*Assets:* In social development theory, the individual skills and strengths that can protect against substance abuse. In this Guide, the term is also used to describe social, fiscal, recreational, and other community support and resources that can be marshaled in the interest of prevention. See also, Protective Factors.

*Baseline Data:* The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

*Component Logic Model:* See Logic Model.

*CSAP's Core Measures:* As used in CSAP terminology, a compendium of data collection instruments that measure those underlying conditions—risks, assets, attitudes, and behaviors of different populations—related to the prevention and/or reduction of substance abuse.

*Defined Population:* In this Guide, the people whose attitudes, knowledge, skills, risks/assets, and behaviors are to be strengthened or changed. Also known in the field as the target group, the population of interest, or the target population/group.

*Domain*: Sphere of activity or affiliation within which people live, work, and socialize (e.g., self, peer, school, workplace, community, society).

*Focus Group:* A representative group of people questioned together about their opinions, usually in a controlled setting.

***OUTCOMES:***
The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes.

***PROGRAM:***
A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population.

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*Goal:* The clearly stated, specific, measurable outcome(s) or change(s) that can be reasonably expected at the conclusion of a methodically selected intervention.

*Incidence:* A measure of the number of people (often in a defined population) who have initiated a behavior—in this case drug, alcohol, or tobacco use—during a specific period of time, usually the past year.

*Indicator:* A substitute measure for a concept that is not directly observable or measurable (e.g., prejudice, substance abuse).

*Logic Model:* A graphic depiction of the components of a theory or program/initiative. In this Guide, two types of logic models are used:

*Program Logic Model*—Shows how all components of the program link together and lead to the achievement of program goals/outcomes.

*Component Logic Model*—Shows how the activities that make up a component of a prevention program link together to achieve immediate and intermediate outcomes (program objectives).

*Objectives:* As used in this Guide, measurable statements of the expected change in risks, assets, or other underlying conditions as expressed in the program's guiding theory of change.

*Outcomes:* The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes.

*Prevalence:* As used in this Guide, numbers of people using or abusing substances during a specified period, usually per year.

*Program:* A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population.

*Program Logic Model:* See Logic Model.

*Protective Factors:* Conditions that build resilience to substance abuse and can serve to buffer the negative effects of risks. Also referred to as assets.

*Proxy Measures:* In this Guide, data that can be used as an indicator—an indirect measure of substance use or abuse. In general, multiple indirect measures (proxies) are more reliable than a single proxy.

*Resilience*: Refers to the ability of an individual to cope with or overcome the negative effects of risk factors or to "bounce back" from a problem.

*Risk Factors:* Conditions for a group, individual, or defined geographic area that increase the likelihood of a substance use/abuse problem occurring.

*Social Indicator:* A measure of a social issue that has been tracked over time (e.g., family and community income, educational attainment, health status, community recreation facilities, per pupil expenditures, etc.) and can be used as a proxy measure.

*Stakeholders:* As used in this Guide, all members of the community who have a vested interest (a stake) in the activities or outcomes of a substance abuse intervention.

*Survey Data:* Information collected from specially designed instruments that provide data about the feelings, attitudes, and/or behaviors of individuals.

*Theory of Change:* As used in this Guide, a set of assumptions (also called hypotheses) about how and why desired change is most likely to occur as a result of a program. Typically, the theory of change is based on past research or existing theories of human behavior and development.

*Underlying Factors:* Behaviors, attitudes, conditions, or events that cause, influence, or predispose an individual to resist or become involved in problem behavior, in this case, substance abuse. See also, Assets and Risk Factors.

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## Logic Model Discussion for Needs Assessment

Look again at the overall program logic model for ACHIEVING OUTCOMES, which is reproduced below as figure 1.1. The shaded area shows how chapter 1, Determine Prevention Needs and Assets, fits into the overall framework. Figure 1.2 on the following page shows the needs and assets assessment component logic model. It is a conceptual map of the activities and tasks that make up the needs and assets assessment component of the ACHIEVING OUTCOMES process. You will find more information about logic models and their role in chapter 4.

Figure 1.1

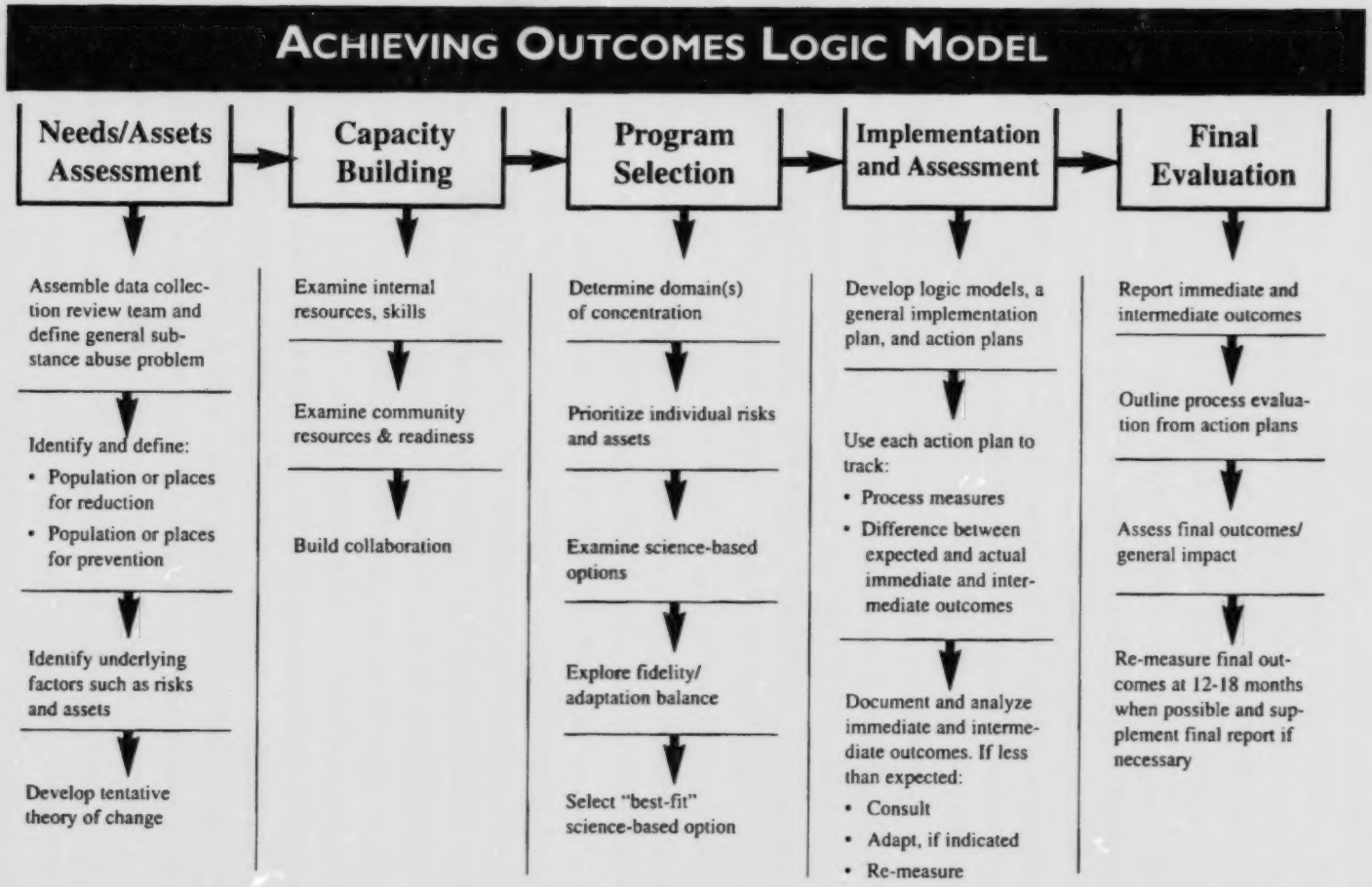


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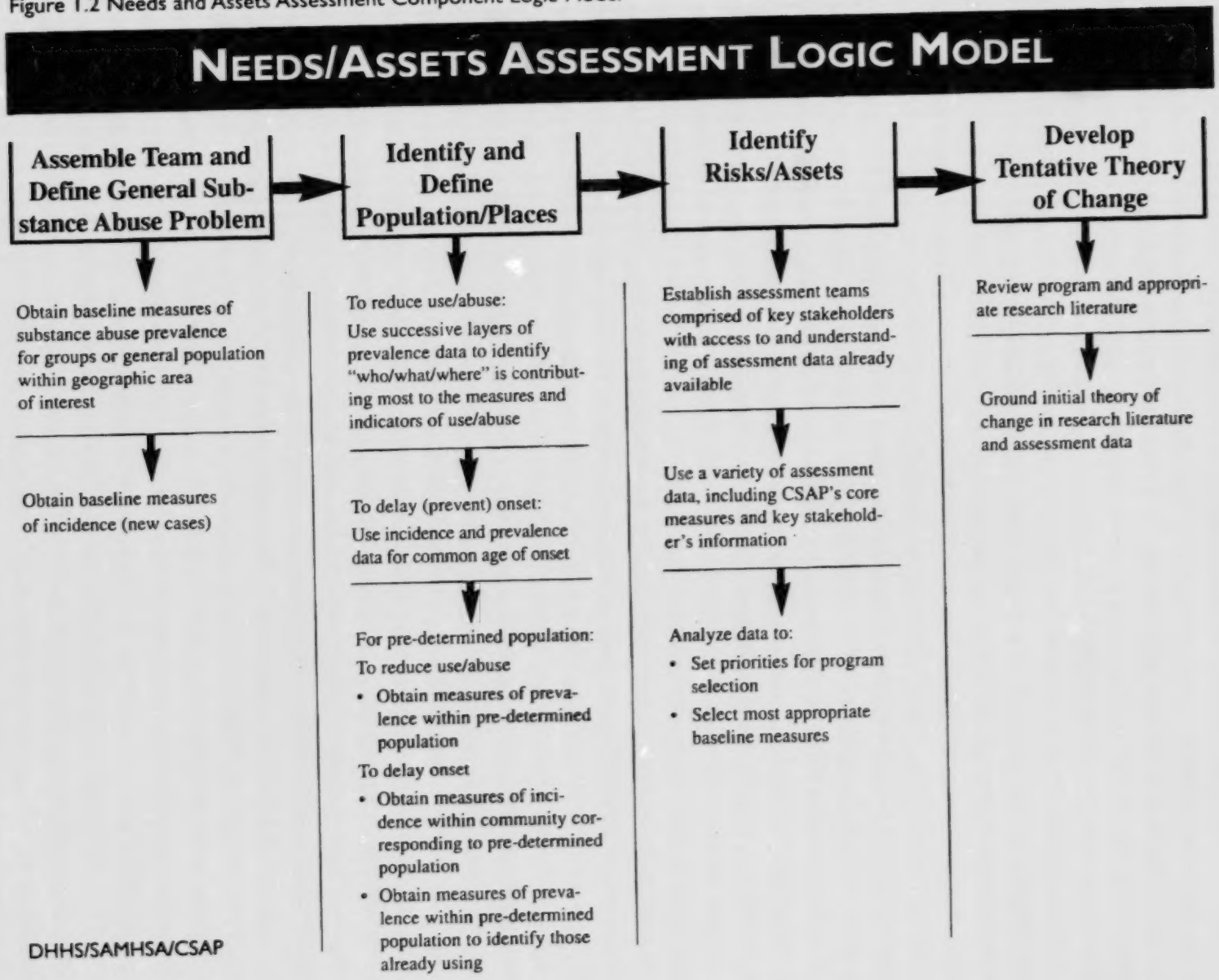
Figure 1.2 Needs and Assets Assessment Component Logic Model

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# Overview

## The Importance of Needs and Assets Assessment to Achieving Outcomes

A needs and assets assessment can identify the unique vulnerabilities and strengths that affect the substance abuse problem(s) in your community. You may have *anecdotal evidence* and perceptions about the overall nature of the substance abuse problem. However, until you gather data that show precisely what is happening, where it is happening, to whom and why, your perceptions and anecdotal evidence may be only a piece of the reality.



A needs and assets assessment has two primary goals: (1) understanding the nature and extent of the general substance abuse problem and (2) identifying the risks and assets that characterize the neighborhoods and/or particular populations that contribute to the problem(s). Your ability to bring about positive change depends on your accurate understanding of the *underlying factors* that increase and decrease the risk for substance abuse. These factors are the behaviors, attitudes, conditions, or events that cause, influence, or predispose an individual to resist or become involved in problem behavior relative to substance use/abuse.

Substance use/abuse prevention programs (which throughout this Guide include environmental interventions) have changed in recent years. Earlier programs focused nearly exclusively on reducing risk factors, a prevention framework popularized in "Communities That Care" (Hawkins, Catalano, et al., 1992). In this context, risk factors are the conditions for an individual, group, or defined geographic area that increase the likelihood of a substance abuse problem occurring. (See figure 1.3: Risk and Protective Factors by Domain.) Today, programs also focus on identifying and developing *protective factors* or assets that create and build *resilience* and can serve as a buffer against the negative effects of risk ("2001 Annual Report of Science-Based Prevention Programs," CSAP, 2001).

These risk and protective factors interact with each other within six domains (see figure 1.3):

- Individual
- Peer
- Family
- School
- Community
- Society

These domains provide a framework for the evolving list of risk and protective factors that research indicates should be targeted by prevention programs. Your programs may need to address several domains to create supportive interactions between adults and young people and among people, neighborhoods, and public sector agencies.

To identify the nature and extent of the substance abuse problem, your team will undertake these related processes:

1. ***Needs assessment***, which can help pinpoint where or for whom prevention and/or reduction efforts will be most productive and identify the underlying risk factors that contribute to the vulnerability of the individual, group, or place of focus; and
2. ***Assets assessment***, which focuses on protective influences and community resources that build resistance to substance abuse.

The picture that results after analyzing these assessments is essential for comprehensive community and program planning. The needs and assets assessment process discloses and measures the substance abuse problem in your community or group. These are your *baseline* measures, the initial information collected prior to an intervention. Baseline measures will help you formulate a measurable goal statement—the measurable change(s) that can be expected at the conclusion of an intervention.

The process will then enable you to identify an appropriate *defined population* (the people whose behaviors, attitudes, and skills about substance abuse you are trying to change or positively reinforce), if a defined population was not pre-selected for you. It also helps you focus your program selection on the underlying risk

Figure 1.3 Risk and Protective Factors by Domain

| Domain | Risk Factors | Protective Factors |
|---|---|---|
| Individual | • Rebelliousness<br>• Friends who engage in the problem behavior<br>• Favorable attitudes about the problem behavior<br>• Early initiation of the problem behavior<br>• Negative relationships with adults<br>• Risk-taking propensity/impulsivity | • Opportunities for prosocial involvement<br>• Rewards/recognition for prosocial involvement<br>• Healthy beliefs and clear standards for behavior<br>• Positive sense of self<br>• Negative attitudes about drugs<br>• Positive relationships with adults |
| Peer | • Association with delinquent peers who use or value dangerous substances<br>• Association with peers who reject mainstream activities and pursuits<br>• Susceptibility to negative peer pressure<br>• Easily influenced by peers | • Association with peers who are involved in school, recreation, service, religion, or other organized activities<br>• Resistance to peer pressure, especially negative<br>• Not easily influenced by peers |
| Family | • Family history of high-risk behavior<br>• Family management problems<br>• Family conflict<br>• Parental attitudes and involvement in the problem behavior | • Bonding (positive attachments)<br>• Healthy beliefs and clear standards for behavior<br>• High parental expectations<br>• A sense of basic trust<br>• Positive family dynamics |
| School | • Early and persistent antisocial behavior<br>• Academic failure beginning in elementary school<br>• Low commitment to school | • Opportunities for prosocial involvement<br>• Rewards/recognition for prosocial involvement<br>• Healthy beliefs and clear standards for behavior<br>• Caring and support from teachers and staff<br>• Positive instructional climate |
| Community | • Availability of drugs<br>• Community laws, norms favorable toward drug use<br>• Extreme economic and social deprivation<br>• Transition and mobility<br>• Low neighborhood attachment and community disorganization | • Opportunities for participation as active members of the community<br>• Decreasing substance accessibility<br>• Cultural norms that set high expectations for youth<br>• Social networks and support systems within the community |
| Society | • Impoverishment<br>• Unemployment and underemployment<br>• Discrimination<br>• Pro-drug-use messages in the media | • Media literacy (resistance to pro-use messages)<br>• Decreased accessibility<br>• Increased pricing through taxation<br>• Raised purchasing age and enforcement<br>• Stricter driving-while-under-the-influence laws |

Adapted from Brounstein, Zweig, and Gardner (1998). *Science-based practices in substance abuse prevention: A guide* and CSAP. *2001 annual report of science-based prevention programs.*

"Drug abuse prevention often involves intervening early to promote healthy development in children and adolescents when the distinction between youths who will subsequently become drug abusers and those who will abstain is unknown. Because many of the young people targeted by prevention services have not yet started to use drugs, the level of need for prevention services cannot be determined simply by counting the number of substance users within the population. Instead, assessing the need for prevention services requires methods for assessing the probability of future drug use within populations that are not currently using substances, and assessing the resources available to reduce the probability."

From Arthur and Blitz, 2000

and protective factors for that defined population or geographic area. The resources that you can draw upon, in terms of both data and community collaborators, will determine the strength of the assessment.

Most needs assessments begin with measures of the *incidence* and *prevalence* of substance abuse. (How and where to find data for these two measures will be explained later in this chapter.) These give you a general understanding of your community's drug problem. Incidence measures the number of people (often in a defined population) who initiated alcohol, tobacco, or illicit drug use during the specified time period. Its special value to prevention practitioners is that when comparable data is available over time, it can be used to approximate age of first use, also called *age of onset*. This information is helpful for practitioners who wish to focus their program on a group that has not yet begun to experiment with drugs (e.g., having a goal of preventing substance use/abuse).

Prevalence is a measure of all users during a specified period, whether or not the behavior is new. This data provides the standard for determining current drug use. Prevalence and incidence may reveal the general substance abuse issues, but usually they do not give you enough direction about who and what are contributing to the problem.

For example, early incidence of alcohol and drug experimentation among youth might appear to be a problem in your community. Once you verify that it is a problem, you still need to determine who and what are contributing to this problem. If you examine only the prevalence of a particular problem (e.g., the number of youth currently using substances), you will not know what you can do to reduce and/or prevent the problem. If, on the other hand, you can determine which groups are most appropriate for prevention programs, and which are most appropriate for reduction programs, you will have made a good start. If you can then isolate which risk factors and assets best characterize your defined population, you can identify and implement programs to reduce those risks and build those assets, thus preventing and/or reducing the problem behavior.

There are, indeed, circumstances in which a population has been defined or chosen for you, or is so obvious that a systematic search may be unnecessary. Many of the risk factors may be known and generally acknowledged to be shared by the group as a whole. However, "knowing" these things does not negate the value of a formal needs assessment.

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There are several reasons. First, if you are a member of a collaborative having multiple interests, the assessment will help identify the collateral needs of families and neighborhoods. Second, while many of the social and economic conditions contributing to substance use/abuse may be clear, the underlying factors for your defined population may still be unique and should be identified. Third, the needs assessment may provide the justification and guidance for adapting a program you are considering. Moreover, solid needs assessment data from your population is helpful if your outcomes from a replicated program are less than expected despite fidelity to the developer's design, as you will see in chapters 3 and 4.

# Conducting the Needs and Assets Assessment

## Define the General Problem and Then Conduct a Multilayered Assessment

Much like peeling back the many layers of an onion to reach the core, successive levels of information about your community's substance abuse problem can be peeled away until you reach the core issues and underlying conditions. For example, as you examine your data, you may determine that substance abuse among young people in your community begins to spike in the eighth grade. This gives you important information about age of onset. When the next layer is peeled, you might then determine that this spike is more apparent among young males in a particular school, neighborhood, or cultural group.

You might also determine from some key *stakeholders* (members of the community who have a vested interest in the activities or outcomes of a program, such as police or court officials) that arrest rates for drug sales and possession are high in this area, indicating that availability of drugs is high. From still others (e.g., school guidance counselors), you might determine that the rates of truancy and academic failure are much higher among your group of youth than the average for comparable communities, or in the state as a whole. Guided by these clues, you can peel the next layer, looking more closely at individual data to identify and examine factors that make this population vulnerable to substance abuse.

It is important that you continue to peel away the layers of information until you reach the critical core. It is the critical core information that will allow you to identify the underlying risks and assets specific to your defined population or area of interest. Most often, this includes data on individuals and may involve confidentiality issues. However, it is not unusual for community stakeholders to share individual level needs assessment data for a defined population as a group, while withholding individual names.

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Another source of individual level data can come from CSAP's recommended *core measures*. This compendium of data collection instruments can provide practitioners with a means of identifying and measuring the individual risks, assets, attitudes, and behaviors within the defined group. While many of the core measures can be administered by practitioners without expert assistance, the administration and analysis of some of these instruments may require specialized help.

Your chances of getting down to the true core of the data you need may increase if you work closely with community collaborators and partners. Your team should be representative of the populations defined through the needs assessment data. Collaborators can facilitate your access to critical data, help obtain data from particular sources, and help interpret the data you already have.

For example, perhaps you have only county-level data, but you want to know how the data breaks down by school. School officials may be reluctant to provide the data. However, if PTA officials make the request and provide legal and confidentiality assurances, school officials may agree to provide the data. And, if a school official is an active member of your assessment team or advisory board, access to data not otherwise shared may be greatly enhanced.

Likewise, you may want to know how the data breaks down by neighborhood. A community planner from your collaborative may have access to this information by ZIP code, and a community leader from the area may be able to enhance your understanding of a particular population. Peel the layers as far as your resources will allow for maximum effectiveness.

Figure 1.4 Sample State and County Needs Assessment Tool

| Lifetime Use by Grade | County X | | | State | | | Ratio |
|---|---|---|---|---|---|---|---|
| Drug | Middle 10-14 | High 15-17 | Total | Middle 10-14 | High 15-17 | Total | Incidence: County/State |
| Alcohol | 39.6 | 66.1 | 52.2 | 38.6 | 68.9 | 52.6 | .99 |
| Cigarettes | 31.2 | 56.5 | 43.2 | 28.9 | 52.3 | 39.7 | 1.08 |
| Inhalants | 13.8 | 12.0 | 12.9 | 12.9 | 10.6 | 11.8 | 1.09 |
| Marijuana | 12.3 | 43.2 | 27.0 | 10.0 | 36.6 | 22.3 | 1.21 |
| Cocaine | 2.3 | 6.9 | 4.5 | 1.9 | 6.5 | 4.0 | 1.13 |

| Lifetime Use by Gender | County X | | | State | | | County/State Ratio | |
|---|---|---|---|---|---|---|---|---|
| Drug | Male | Female | Total | Male | Female | Total | Male | Female |
| Alcohol | 52.2 | 51.6 | 51.9 | 52.8 | 52.4 | 52.6 | 0.98 | 0.98 |
| Cigarettes | 45.1 | 41.6 | 43.4 | 39.4 | 39.8 | 39.7 | 1.14 | 1.04 |
| Inhalants | 14.0 | 12.4 | 13.2 | 12.4 | 11.3 | 11.8 | 1.13 | 1.09 |
| Marijuana | 30.8 | 23.4 | 27.1 | 24.6 | 20.2 | 22.3 | 1.25 | 1.16 |
| Cocaine | 5.5 | 3.4 | 4.5 | 4.4 | 3.8 | 4.0 | 1.14 | 0.89 |

| 30-day Use by Grade | County X | | | State | | | Transition to High School | |
|---|---|---|---|---|---|---|---|---|
| Drug | Middle 10-14 | High 15-17 | Total | Middle 10-14 | High 15-17 | Total | County X | State |
| Alcohol | 21.1 | 40.6 | 30.4 | 20.4 | 43.4 | 31.0 | 1.92 | 2.13 |
| Cigarettes | 13.1 | 26.2 | 19.3 | 9.8 | 21.7 | 15.3 | 2.0 | 2.21 |
| Inhalants | 6.9 | 3.6 | 5.3 | 5.7 | 3.2 | 4.6 | .52 | .56 |
| Marijuana | 6.9 | 22.4 | 14.3 | 5.1 | 18.3 | 11.2 | 3.24 | 3.59 |
| Cocaine | 1.2 | 2.5 | 1.8 | .08 | 2.0 | 1.4 | 1.67 | .25 |

| 30-day Use by Gender | County X | | | State | | | County/State Ratio | |
|---|---|---|---|---|---|---|---|---|
| Drug | Male | Female | Total | Male | Female | Total | Male | Female |
| Alcohol | 33.0 | 28.4 | 30.4 | 31.2 | 30.7 | 31.0 | 1.06 | .93 |
| Cigarettes | 21.6 | 17.4 | 19.3 | 15.2 | 15.3 | 15.3 | 1.2 | 1.14 |
| Inhalants | 4.9 | 5.8 | 5.3 | 4.8 | 4.3 | 4.6 | .11 | 1.16 |
| Marijuana | 19.4 | 10.0 | 14.3 | 13.0 | 9.6 | 11.2 | 1.49 | 1.04 |
| Cocaine | 3.0 | .09 | 1.8 | 1.6 | 1.2 | 1.4 | 1.88 | .08 |

From Florida Department of Children and Families, 2000.

*1. Alcohol and cigarette use begins early, but cigarette use continues to surpass the statewide averages through high school.*

*2. Marijuana use also begins early, escalates in high school, and is above the state average.*

*3. Early initiation of marijuana and inhalants is higher in County X than in the state and continues through high school.*

*4. Alcohol, cigarette, marijuana, inhalants, and cocaine use all begin early in County X.*

*5. Cigarette, marijuana, inhalants and cocaine use continue throughout high school, with use by both males and females exceeding state averages.*

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Figure 1.4 reflects actual needs assessment data obtained from a recent state needs assessment. Lifetime use (incidence) includes information about "one-time" use, as well as more frequent use. Thirty-day use (prevalence) more closely reflects the population of regular users. Note the increases between middle and high school. Note also the gender differences. Analysis of these charts would suggest that cigarette, marijuana, inhalants, and cocaine use, beginning in middle school and accelerating in high school, are problems for County X. While this is more the case for boys than girls, the prevalence for girls is also higher than state averages, with the exception of female cocaine use. Cocaine use is comparatively high for males, but the actual numbers are so small that addressing that issue may not be the best use of resources, if they are limited.

This example demonstrates how you can begin to define your population of interest (if the population was not pre-selected for you). Such charts and surveys can be difficult and confusing to analyze, and you should feel comfortable in seeking help if necessary.

Assessment tools such as this example can help identify the general substance abuse problem. But if you are operating at a local level, you will need to peel back more layers. The identification of early use of cigarettes, marijuana, inhalants, and, to a lesser extent, cocaine by middle and high school boys does not yet identify your target population within your community or, for that matter, within any single community within County X. Where are these students? Where do they live? What schools do they attend? This is the kind of necessary, detailed information that is not available from *survey data* and that you may have to obtain, instead, through key stakeholders.

## Identify and Define a Population and/or Geographic Area

Your ability to bring about positive change depends on the extent to which you can accurately connect people and places with interventions. For example, if your mandate or goal is to "reduce" substance abuse, you must identify the precise group that is contributing most to the high numbers that demonstrate abuse. Your programs should be targeted to that group. Otherwise your chance of actually reducing substance abuse in a specific community is compromised.

Once you have specified and identified the population of interest, you can identify the risk and protective factors of the individuals who make up this population. You can then select a program that addresses their specific needs. (See chapters 3 and 4 for information on program selection and implementation.)

If, on the other hand, your mandate is to "prevent" substance abuse, you may want to identify the most common age of onset of substance abuse and focus your programmatic efforts on the age group directly below this age of onset. See case example B below.

As previously mentioned, it is not uncommon for a defined population to be pre-determined for a prevention program or collaborative. It is the population you will need to serve to meet the requirements of your funder and/or local political environment. As the examples below illustrate, however you end up with a defined population, your *goals* and *objectives* will relate to what can be accomplished within this defined population (be it reduction or prevention).

**Example A: "REDUCTION in Substance Use and Abuse"**

*A county survey helped to identify marijuana use among youth in a small Midwestern town as a prevalent problem. Further assessment included local hospital and sheriff's data and then key stakeholder interviews with the mayor and council and assistant middle and high school principals. This assessment identified a core group of adolescent boys at three middle schools as those primarily involved in this behavior. Additional assessment undertaken by school guidance staff revealed that these boys shared a range of risk factors: poor school performance, dysfunctional family life, and negative peer influences.*

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*In response to these conditions, the local prevention planners might choose* ***"reducing marijuana use and related behaviors among middle school children"*** *as a priority in their community. To succeed, the population responsible for the substance abuse (in this case, the core group of adolescent boys at three middle schools) will need to be specifically addressed. Successful outcomes will be achieved by selecting a program(s) that effectively address(es) the underlying factors (e.g., poor school performance, dysfunctional family life, negative peer influences) that the school guidance counselors identified as characteristic of these boys.*

***It is important to note that many practitioners select "reduction of substance abuse" as a goal (often under pressure from funders), but then fail to define the population responsible for the high rate of substance use, seriously jeopardizing goal attainment.***

**Example B: "PREVENTION of Substance Use and Abuse"**

*A needs assessment from a rural, largely Hispanic, county revealed that the school dropout rate hovered around 40 percent. Many of these youth hung out near certain "hot spots" on the commercial strips. A local partnership, determined to make a difference, worked with a nearby college to develop a needs assessment plan that would allow the partnership to address two problems of acute concern: high rates of alcoholism, observable as well as corroborated by county health data, and school dropout rates 2.5 times the state norm.*

*A comprehensive needs assessment that began with the dropouts themselves revealed that many of the dropouts shared a risk factor of early initiation of alcohol use (typically at age 10). The families of these youth also complained of bicultural stress: that is, stress associated with living in a culture different from their own. Further assessment revealed that many of these youth had younger siblings who were not yet using alcohol, but who were at high risk of doing so if family patterns held true.*

*With much discussion about potential approaches to the needs assessment findings, the partnership formulated an intervention plan for the out-of-school youth with one of the county's*

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*vocational development programs. The partnership then focused on the younger siblings. It decided to establish a goal of* ***"preventing the early use of alcohol."***

*In funder's terms, the goal was to increase the age of onset of alcohol for the county's high-risk youngsters. To accomplish this goal, the collaborative developed an afterschool and weekend prevention program for the sibling group. The program provided multiple opportunities, both structured and unstructured, for the siblings to develop academic competencies and social skills to help them stay in school. In addition, a structured family therapy program addressed family stress from biculturalism and parenting skills. Over time, many of the older siblings participating in the program volunteered for, and were trained as, mentors and counselors.*

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## Identify Risk and Protective Factors for Your Defined Population

The *archival data* you collect, which may be similar to that shown in figures 1.5 and 1.6, can provide guidance for where to begin your search for the risks and assets that are particular to your group. However, county level, or even community level, data may or may not be characteristic of your group. The further removed the data from your specific population, the greater the risk of a mismatch between your population or defined area and the selected program. The section on data collection in the second half of this chapter provides information on how to use different types of data to identify risk and protective factors for your defined population.

Figure 1.5 Example of a County Protective Factors Assessment

| Domains | | Protective Factors (A score of 50 is national average.) Above 50 denotes elevated protection—indicated by Δ. | County X | Like County | State |
|---|---|---|---|---|---|
| Community/Society | | Community Rewards for Prosocial Involvement | 47 | 47 | 48 |
| Family | Δ | Family Attachment | 51 | 52 | 51 |
| | Δ | Family Opportunities for Prosocial Involvement | 53 | 52 | 53 |
| | Δ | Family Rewards for Prosocial Involvement | 52 | 52 | 52 |
| School | | Opportunities for Prosocial Involvement | 49 | 49 | 50 |
| | | Rewards for Prosocial Involvement | 43 | 46 | 45 |
| Individual/Peer | Δ | Religiosity | 52 | 49 | 48 |
| | Δ | Social Skills | 54 | 53 | 53 |
| | Δ | Belief in the Moral Order | 53 | 55 | 53 |

From Florida Department of Children and Families, 2000.

Figure 1.6 Example of a County Risk Factors Assessment

| Domains | | Risk Factor (A score of 50 is national average.) Above 50 denotes elevated risk—indicated by Δ. | County X | Like County | State |
|---|---|---|---|---|---|
| Community/Society | Δ | Low Neighborhood Attachment | 56 | 56 | 56 |
| | | Community Disorganization | 49 | 51 | 53 |
| | Δ | Personal Transitions and Mobility | 60 | 60 | 59 |
| | Δ | Community Transitions and Mobility | 55 | 53 | 52 |
| | | Laws and Norms | 45 | 44 | 43 |
| | | Perceived Availability | 44 | 44 | 42 |
| Family | Δ | Poor Family Supervision | 52 | 50 | 50 |
| | Δ | Poor Family Discipline | 57 | 52 | 53 |
| | | Family History of Antisocial Behavior | 48 | 50 | 47 |
| | | Parental Attitudes Favorable to Drug Use | 46 | 47 | 46 |
| | | Parental Attitudes Favorable to Antisocial Behavior | 47 | 48 | 48 |
| School | Δ | Academic Failure | 59 | 59 | 60 |
| | Δ | Low School Commitment | 54 | 52 | 51 |
| Individual/Peer | | Perceived Risks of Drug Use | 38 | 40 | 39 |
| | Δ | Early Initiation | 52 | 49 | 49 |
| | Δ | Impulsiveness | 53 | 54 | 53 |
| | | Sensation Seeking | 50 | 49 | 48 |
| | | Rebelliousness | 44 | 43 | 43 |
| | Δ | Friends' Delinquent Behavior | 56 | 54 | 55 |
| | | Friends' Use of Drugs | 50 | 49 | 47 |
| | | Peer Rewards for Antisocial Behavior | 46 | 43 | 41 |
| | | Favorable Attitudes Toward Antisocial Behavior | 40 | 37 | 37 |
| | | Favorable Attitudes Toward Drug Use | 47 | 47 | 46 |

From Florida Department of Children and Families, 2000.

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## Develop a Theory of Change Grounded in Needs Assessment Data

The preceding examples show how needs assessment data can be used to inform decisions about how and to whom to address prevention and reduction efforts. The linkages you make between the information from your needs and assets assessment and your defined population will enable you to develop your goals and objectives, and, ultimately, your *theory of change*.

*Goals* are simply a clear statement of the results to be achieved—the final, measurable outcomes of a prevention program. The statement draws on the needs assessment data that describes and provides measures of the general substance abuse problem(s) you wish to change. Goals should be achievable within the timeframe of the intervention. Reducing substance abuse for 15 percent of the high school youth identified as "users" in your community is an achievable goal; eliminating substance abuse altogether may not be. For instance, a community partnership or coalition might set a goal to significantly decrease the use of alcohol and drugs among 90 percent of the teens between the ages of 14 and 18 who are using alcohol and drugs. For a smaller organization, perhaps a single service agency, your goal might be more limited in scope: to eliminate the use of tobacco products among the middle school youth who use tobacco products and who participate in three community boys and girls clubs.

A goal is comprised of a number of objectives. *Objectives* are the stepping stones to goal achievement. They are statements of the change(s) that you expect to occur in relation to the baseline measures of your defined population's risks and assets. This change is brought about by the particular components in your prevention program that address those particular risks and assets.

Your goal should relate to your final outcomes, and your objectives should relate to your shorter-term (immediate and intermediate) outcomes, as explained in later chapters. Collectively, goals and objectives specify and describe the changes you hope to accomplish through your prevention program.

Upon completion of the analysis of your needs and assets data, you next formulate a set of assumptions (often referred to as hypotheses) about how and why desired changes are most likely to occur as a result of your program. A review of the pertinent literature will help you formulate these assumptions. This important step is known as developing your theory, or theories, of change.

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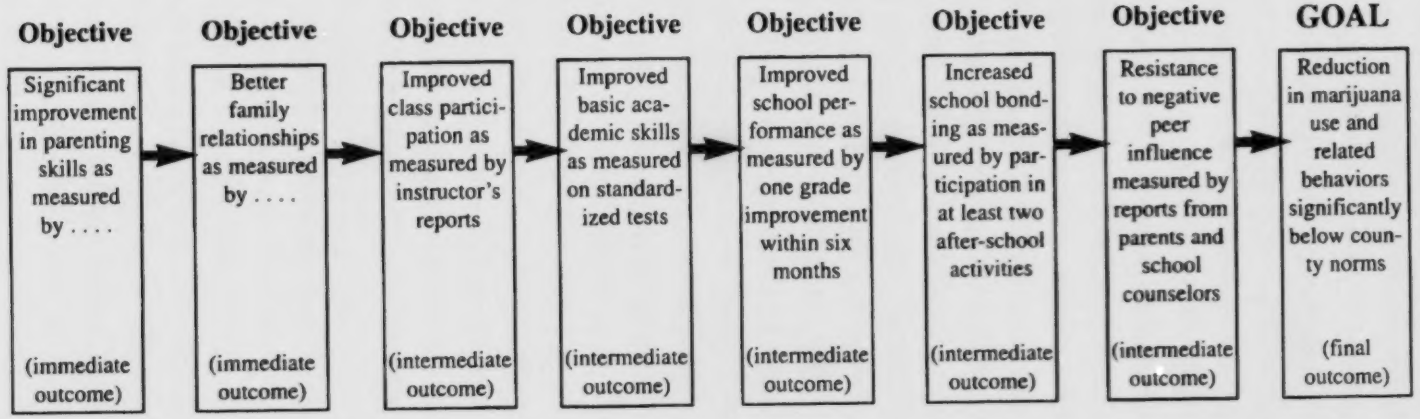
Developing your theory of change is an instrumental part of establishing your goals (final outcomes) and your objectives (immediate and intermediate outcomes). Later chapters will provide more detailed information to assist you in understanding the theory of change as part of building a *logic model* for your program.

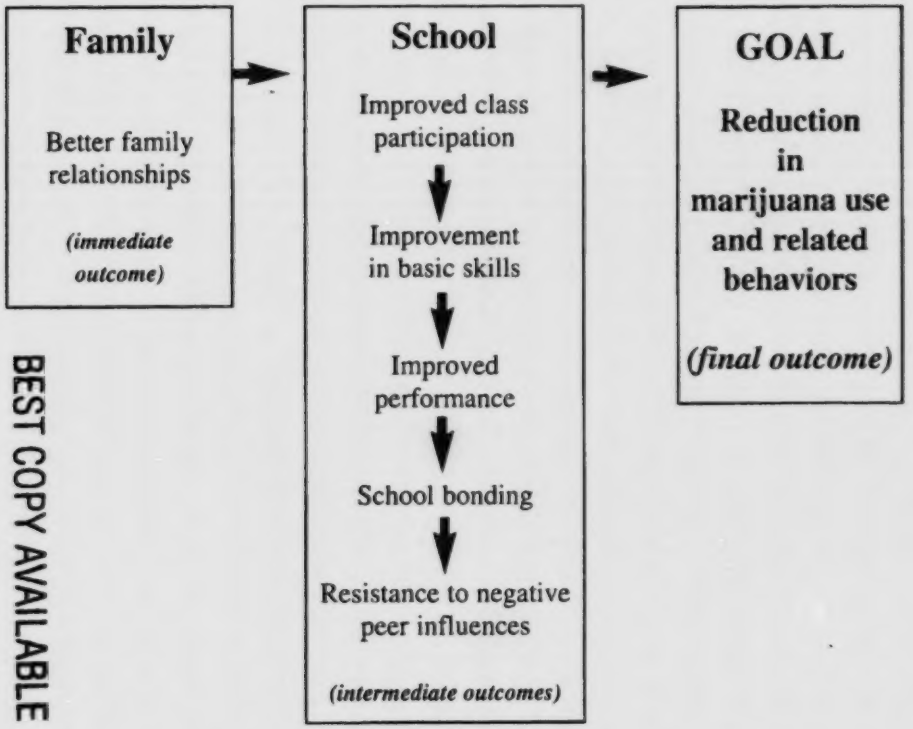
For instance, in the previous Example A, "Reduction in Substance Use and Abuse," the goal or final outcome desired by the community is to "reduce marijuana use and related behaviors among middle school children." The objectives, which reflect the identified risk factors, might be to improve school performance for the defined population, to bolster family relationships and parenting skills, and to enhance resilience to negative peer influences.

After reviewing the research literature relevant to this issue and population, your theory of change to achieve the goal for this example might be stated in this way:

**Improved family parenting skills (immediate outcome) lead to better family relationships (immediate outcome), which lead to renewed focus on schoolwork (intermediate outcome), which leads to improved basic academic skills (intermediate outcome), which lead to improved academic performance (intermediate outcome), which leads to increased school bonding (intermediate outcome), which reduces the impact of negative peer influences (intermediate outcome), which leads to a reduction in marijuana use (final outcome).**



Or, the objectives could be grouped by domains and look like this instead:

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The graphics shown above and on the previous page constitute a logic model for your theory of change. Logic models are a useful way to conceptually map the changes you hope to achieve, as will be explained further in chapter 4.

As you can already see, achieving outcomes depends in large part on the data you collect—the foundation on which you assess needs and assets, identify the substance abuse problem, define the population, set your goals and objectives, and develop your theory of change. The remaining sections of this chapter provide an overview of various methods of data collection, analysis, and use.

# Data Collection and Effective Use

Data—collected from archival records and databases, surveys, interviews, focus groups, direct observation, stakeholder input, and CSAP's core measures—provide the foundation for a multilayered assessment of prevention needs and assets. The following steps addressed in this part of ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION will help you understand the importance of finding and using data effectively:

- Identification
- Collection
- Analysis
- Expert guidance when needed
- Ongoing assessment

## Identification of Data

You can find information about substance use/abuse behaviors and the underlying risk factors and conditions that contribute to the problems from a variety of data. If you cannot pinpoint the information directly, you can use *indicators* (substitute measures for a concept that is not directly observable), or proxies, to determine how prevalent certain problems and other risk factors may be in your community. Because the concepts are not directly observable, the use of several *proxy measures* will build a much more reliable indication of a concept than just a single proxy by itself.

Figure 1.7 suggests sample indicators that can be used as proxies for general family and community level risk and protective factors. Research has shown these to be good proxy measures. For example, you cannot take a direct measure of how unhappy an individual might be. But you *can* measure the symptoms of unhappiness, such as short attention span, difficulty sleeping or sleeping too much, and general depression. Similarly, when you cannot measure a specific risk factor, you look for symptoms of the risk, as also demonstrated in figure 1.7.

| Risk Factors | Proxy Indicators |
|---|---|
| Early and Persistent Antisocial Behavior | • Elementary school emotional disturbance placement statistics<br>• School incident reports<br>• Juvenile arrest statistics |
| Family Management Problems | • Children living away from parents<br>• Runaway statistics |
| Low Commitment to School | • Percent of students who drop out<br>• Truancy reports |
| Transitions and Mobility | • Number of new homes constructed<br>• Number of households in rental properties<br>• Net migration of students in and out of schools |

**Figure 1.7**
**Sample of Selected Risk Factors and Associated Proxies**

*Social indicators* are measures of social issues that have been tracked over time (e.g., family and community income, educational attainment, health status, community recreation facilities, per pupil education expenditures, etc.). Social indicators are often used to document levels of community and group risk and to serve as proxies for the existence of social problems, such as substance use/abuse. Sample community and family level indicators are shown in figure 1.8.

Data fall into two broad categories:

***Archival Data***—This is information stored or archived on a periodic basis, and it is generally the simplest kind of data to gather. All types of agencies keep records and collect data—school districts, police departments, hospitals, child abuse referral hotlines, etc. Often this data can be used directly or indirectly to establish an overall picture of substance abuse within the geographic area served by that agency.

***Survey Data***–This is information gathered from specially designed instruments that provide data about the feelings, attitudes, and/or behaviors of individuals within specific populations. Collection of this data can yield valuable and detailed evidence about the substance use/abuse behavior, risks, and assets for groups of people (as in figures 1.4 through 1.6), and, therefore, what they may be for your defined population. You will then have to collect more detailed information to pinpoint the specific risks and assets for your defined population.

Typically, surveys are more costly and more difficult to conduct than the mere collection of existing archival data. Nevertheless, many states and communities routinely collect survey data.

Survey data can be collected in a variety of ways: paper and pencil questionnaires, telephone or face-to-face interviews, and checklists. You may need to collect survey data from persons who represent otherwise hard-to-access individuals or populations (proxies). You can also collect survey data through key stakeholders, who then can provide information about the behavior and characteristics of the individuals under study or linkages to other individuals and agencies that have this information.

Figure 1.8 Sample Community and Family Indicators

| Social Indicators | Risk Factors (i.e., Problems) | Protective Factors (i.e., Assets) |
|---|---|---|
| Economic Status of Families | • Number of families living below the poverty line<br>• Number of families living in shelters<br>• Rate of "doubled up" housing families<br>• Rate of families without health insurance coverage | • Number of community organizations providing emergency services (e.g., food, shelter) to families<br>• Number of community organizations providing services beyond the crisis situation to families (e.g., job placement, skills training, etc.) |
| Neighborhood Organization | • Rate of population turnover in a community<br>• Heterogeneity of the environment<br>• Incidence of graffiti, abandoned lots/buildings<br>• Number of violence and felony offenses by ZIP code or census tracts<br>• Number of drug-related offenses by ZIP code or census tracts<br>• Number of facilities selling alcohol by ZIP code or census tracts | • Number of faith-based organizations<br>• Number of resident volunteer neighborhood organizations and services<br>• Rate of participation in elections (national, state, and local)<br>• Participation of police/community council meetings<br>• Participation at community board meetings |
| Social Behavior of Children and Adolescents | • Number of reported school disciplinary incidents<br>• Rate of truancy<br>• Rate of juvenile offenses—drug-related, violent, property<br>• High child-to-teacher ratio in schools | • Number of afterschool recreational programs<br>• Number of alternative schools for youth with disciplinary problems<br>• Involvement of police in truancy enforcement<br>• Number of juvenile court rehabilitation services<br>• Participation of parents in school meetings |
| Family Management and Parenting Practices | • Number of single-parent homes<br>• Number of single parents working two jobs | • Number of agencies providing sufficient child care services<br>• Number of agencies providing parenting and family skills development services |
| Family Behavior Concerning Substance Abuse | • Number of adult offenders who have children who appear in Family and Criminal Court for substance abuse-related offenses | • Number of in- and out-patient substance abuse treatment facilities for parents and children<br>• Community norms, as measured by number of substance abuse-related hospital admissions |
| Family Conflict | • Number of parental petitions of neglect filed in Family Court<br>• Number of foster care placements<br>• Number of kinship placements outside of the home<br>• Number of reported domestic violence calls for service<br>• Number of children with incarcerated or criminally involved parents | • Number of agencies offering family conflict resolution skills training<br>• Number of family violence shelters and agencies<br>• Number of family intervention specialists<br>• Average number of child services agency contacts for home visitation to monitor serious problem situations<br>• Presence of child abuse prevention programs |

You may also encounter references to two types of data within the broad archival and survey categories: quantitative and qualitative:

**Quantitative (objective) data** can refer to both statistical reports and surveys. Drug use surveys, arrest reports, emergency room admissions, and traffic reports are typical of quantitative data. Quantitative data consist of counts, rates, or other statistics that document the actual existence or absence of problems, behaviors, or occurrences.

**Qualitative (subjective) data** reflect individual and community perceptions gleaned from focus groups, stakeholder interviews, and surveys. This type of data results in descriptions of problems, behaviors, or events. It is possible to add a quantitative component to qualitative data (e.g., of the 1,200 young people interviewed, 400 reported weekly alcohol use).

Because qualitative information can reflect the feelings and thoughts of people similar to those you will be working with, it often enhances the value of the available quantitative data. You may find it useful in persuading various audiences about the difference your prevention initiative can actually make in the lives of people within a particular community.



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## Data Sources

Practically speaking, it is helpful to think about data on different levels. Each level addresses the substance abuse patterns of a different universe of people. For example, national surveys and the like may shed light on the beliefs and behaviors of all middle school children in the country. A state survey may report the very same data for the middle school children in that state, perhaps even comparing its children to national averages to identify the existence of a problem. A county survey may collect and report the very same data as the state, comparing its findings to the rest of the state and perhaps comparing its children to those in other socially similar counties, and so on, down to the school district, or local, level.

Notice that each level of data reflects the substance abuse attitudes and behaviors of a narrowing band of people. As you move from a general overview to increasingly smaller and more specific groups, the data from the preceding level helps focus attention more accurately and effectively on what is needed at the next level to clarify the problem.

Collecting the level of data needed to accurately link individuals or specific geographic areas with programs can be a formidable challenge for the community practitioner. Making a mistake at this point in the needs assessment can doom your program to failure. This can happen if you either define a group or place that is inappropriate for your goal, or if you assume that national, state, county, or school district data are representative of your more specific community- or neighborhood-based group. If you fail to narrow your defined group appropriately, you almost certainly will not be able to select a program that addresses the group's very specific risk and protective factors, and you jeopardize your likelihood of achieving outcomes.

For instance, if your school district data indicates that there is a spike in marijuana use at the eighth grade, you must dig down deeper to determine which eighth graders are responsible for that spike and what their very specific and individual risk and protective factors are before you can select the most effective program. Narrowing your focus to just one or two specific middle schools may not be enough; you must focus very specifically on the individuals involved in the problem behavior. It is the risks and assets of those individuals that will inform which program has the greatest probability of success.

Even if you are given a program and a defined population, you should collect the data to determine the very unique characteristics of this specific population in your community. Having this data will then

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### Needs Assessment Tool

Located on the CSAP Decision Support System Web site, this online tool will help you gather preliminary data so that you can make informed decisions about potential next steps in building your prevention program.

**Online sources that may be useful as you collect data for your needs assessment:**

*CSAP's PREVLINE*—Contains links to 20 data sources: www.health.org

*Office of National Drug Control Policy*—Lists 30 links to data surveys and sources: www.whitehousedrugpolicy.gov/

*National Criminal Justice Reference Service*—Contains links to many sources of national and state crime statistics: www.ncjrs.org

*Centers for Disease Control and Prevention*—Contains links to many sources, including the Youth Risk Behavior Surveillance System survey: www.cdc.gov/

*State of the Nation's Cities Report*—Provides database on American cities and suburbs (includes data on items such as employment, income, land development): www.policy.rutgers.edu/

enable you to decide if the program you have been given must be adapted to fit your defined population's needs (see chapters 3 and 4 for more on program fidelity and adaptation).

The remainder of this section addresses a variety of data sources already available to you and what kinds of additional data you might need to collect on your own. As you might expect, the hardest kind of data to collect is community, neighborhood, and individual data. Yet, if you are a practitioner working with a population group more specific than the county level, your success depends on it.

**National Data**

There are a number of national surveys and databases that can be useful in understanding potential problem substance abuse areas for your community and even identifying potential defined populations. Examples of national surveys include the National Household Survey on Drug Abuse, the Youth Risk Behavior Surveillance System survey, and the Monitoring the Future Survey. Figure 1.9 describes these and other surveys and the kinds of information they report.

**State and County Data**

State and county data may be available to you from various sources, such as agencies providing child and family services (e.g., drug-affected babies); law enforcement agencies (juvenile and adult arrests for drug offenses); department of transportation (alcohol-related traffic deaths and accidents); and the state medical examiner (drug-related deaths).

The Center for Substance Abuse Prevention (CSAP) has funded large-scale needs assessments in many states and territories, which have included community-level school surveys. In states/territories that have received CSAP funding for a needs assessment project, this data should be available from your state agency responsible for substance abuse prevention.

Additionally, many national surveys now have data analyzed for the state or sub-state level.

**Community and Individual Data**

While there may be some local data available to you (e.g., school district surveys), it is likely that you will have to engage in hands-on data collection at the local level, making particular use of key stakeholders in law enforcement, at the school level, and within neighborhoods. At this stage in your needs assessment,

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Figure 1.9 National Data Sources

| Name | Agent | Purpose | Survey Characteristics |
|---|---|---|---|
| National Household Survey on Drug Abuse (NHSDA) | Substance Abuse and Mental Health Services Administration (SAMHSA/DHHS) | Estimates the prevalence and incidence of illicit drug, alcohol, and tobacco use in the household population. | Representative sample of subjects in households age 12 years and older. A total of 25,500 persons were interviewed for the 1998 survey. |
| Monitoring the Future | University of Michigan | Estimates beliefs, attitudes, and behavior of young people in the U.S. | Representative sample of 8th, 10th, and 12th graders in schools throughout the U.S. |
| PRIDE Annual Survey | Parents Research Institute for Drug Education (PRIDE) | Survey primarily used by schools, communities, and states to gather data on teenage drug and alcohol use. | Opportunistic sample of youth in schools. Schools invite PRIDE to conduct its survey of youth from the 6th through the 12th grades. |
| Partnership Attitude Tracking Survey | The Partnership for a Drug-Free America (PDFA) | Study monitors drug-related behavior and attitudes among children, teens, and parents. It is the largest, ongoing research on drug-related attitudes in the U.S., and the only ongoing drug survey that collects data on children as young as eight and nine. | Surveys teenagers across the country through self-administered, anonymous questionnaires. |
| Back to School Survey | The National Center for Addiction and Substance Abuse at Columbia University (CASA) | Tracks teens' attitudes toward substance abuse and the opinions of parents, teachers, and principals. The survey is used nationally to gauge adolescent drug and alcohol use. | The first national survey conducted of teachers, principals, teens, and parents on substance abuse in the nation's schools. The survey was conducted June 7–July 7 (1997) of 1,115 teens (ages 12 to 17), 998 parents (648 teens and parents from the same households), 789 middle (grades 6-8) and high school teachers (grades 9-12), and 401 middle and high school principals. |
| Drug Abuse Warning Network (DAWN) | SAMHSA/DHHS | Tracks trends in emergency departments (drug-related episodes, drugs of special interest) and medical examiners' reports (drug-induced and drug-related deaths, demographic characteristics, and frequency of mentions for particular drugs). | The Drug Abuse Warning Network (DAWN) is an ongoing drug abuse data collection system sponsored by SAMHSA's Office of Applied Studies. |
| Arrestee Drug Abuse Monitoring Program (ADAM) | National Institute of Justice (NIJ) | Provides community-specific information about drug use among the arrestee population. | In 1998, ADAM conducted interviews and drug tests on more than 30,000 arrestees. |
| Youth Risk Behavior Surveillance System (YRBSS) | Centers for Disease Control (CDC/DHHS) | Determines the prevalence and age of initiation of health risk behaviors; assesses changes in health risk behaviors; and provides comparable national, state, and local data. | Representative sample of students grades 9-12 in public and private schools in the 50 states and the District of Columbia. The 1999 survey had more than 15,000 respondents. |
| Treatment Episode Data Set (TEDS) | SAMHSA/DHHS | Provides descriptive information about the national flow of admissions to specialty providers of substance abuse treatment. | Representative of 1.5 million substance abuse treatment admissions annually. |

you are focusing on the risk and protective factors of individuals or specific community areas. It is unlikely that this data has already been collected in a comprehensive manner, if at all. The following section on data collection outlines how you might go about collecting this individual and community-level data. See also the sidebar below on community-level sources of data.

## Community-Level Sources of Data

*Adapted from National Institutes of Health, 1998.*

It is not easy to identify sources of information at the community level; find out the types of information available; and establish ways to obtain the information initially and, perhaps, periodically. Information about drug abuse is likely to be confidential. The people responsible for collecting and reporting about drugs are usually very busy, and they may have reservations about sharing information.

If a network does not already have connections with community data sources through its members, there are two ways to start the process of identifying sources. They both can be done concurrently. The first way is to get local telephone numbers of criminal justice, health, and treatment agencies, so that calls can be made to identify potential data sources. The mayor's office, chamber of commerce, or a similar source may have a directory of human resource organizations, or simply use the local telephone directory. Community or local telephone books generally specify pages for telephone numbers of local police and sheriff departments. The regular telephone directories may list these under Government Listings. Hospital and treatment programs may be listed in the yellow pages or the business section (by name). Support staff at network-backed agencies may be helpful in this task.

The second way to start identifying potential information sources at the community level is to start at the top and work down. To identify sources of arrest data, for example, begin by calling individuals at the state alcohol and drug abuse agency who can identify and provide a list of the substance abuse treatment programs that are located within or serve particular communities. Call the state police department and the UCR office to find out who their contacts are at the local level. In trying to identify individuals and departments within hospitals, contact representatives of the state health department to find out what and whom they know.

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## Data Collection

You may need to assemble a team to help with data collection. This team might include individuals with particular expertise in data collection and/or ties to, or influence with, those in control of local data sources. Often stakeholders or partners are included, because they are well positioned to provide information within their areas of responsibility. These may be school principals, teachers, school counselors, probation officers, caseworkers in the social service system, administrators of homeless shelters, police and housing authority personnel, medical practitioners, and others.

The data collection team becomes a resource to: (1) provide access to data, which may be difficult to collect; (2) help identify underlying risk and protective factors; (3) serve as liaison to others in the community with relevant expertise; and (4) enrich the data interpretation with knowledge of the population, policy, or environment you plan to address.

As discussed above, most data collection relies on one or several of the following:

- Archival data from community commissions, agencies, and other sources
- Surveys based on self-administered questionnaires
- Interviewer-administered instruments (from key stakeholders, service providers, or defined population surveys)
- Focus groups
- Direct observations
- Review of archival records and databases (not created primarily for the purpose of the needs assessment)
- CSAP's core measures

Each of these data sources can provide useful needs and assets measures. The selection of data sources will depend on your defined population or your community of interest. Ideally, you will use multiple data sources, because the biases inherent in one source can be balanced by another source. CSAP's core measures can be helpful as you collect your individual level data. Core measures that focus on those underlying conditions most generally related to substance abuse can provide you with a means of identifying and

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measuring the individual risks and assets within your defined population. The following scenario illustrates examples of different data collection methods and how they can be utilized together:

**Example: "Combining Data Collection Methods Effectively"**

*A mid-sized town in Texas was stunned when a two-car accident resulted in the deaths of two local teens and the serious injury of four other young people. Local authorities determined that alcohol and illicit drug use by the drivers of the two cars was the primary cause of the accident. Determined not to let this kind of tragedy occur again, citizens and family members together began to look at their community to learn what they needed to do.*

*First, they explored county records of car accidents and emergency room admissions related to late night injuries. They also worked with law enforcement officials who helped a committee examine arrest records for driving-related offenses. They worked with criminal court administrators to examine the outcome of judicial proceedings related to these arrests. From local law enforcement officials, they also obtained information about the laws related to possession of alcohol and other drugs by minors and enforcement of those laws. They probed existing data for re-formulation of laws in the interest of community mobilization.*

*Next, they held a focus group with teenagers from the same high school attended by the youth involved in the accident. They explored the thoughts, feelings, experiences, assumptions, etc. of the participants and learned that alcohol and drug use among high schoolers was more prevalent than they imagined. Many of the students were troubled by it, too.*

*They also learned that the school had conducted an anonymous survey in the past year that covered student substance use and related student characteristics. The survey results were shared, thanks to school administrators who were part of the team. They continued collecting additional data in accordance with a comprehensive plan developed by the team responsible for framing the questions that needed to be reliably answered.*

*Volunteers interviewed key persons in the community to get their personal opinions about the problem. They interviewed the sheriff, the high school principal, several teachers, guidance*

*counselors, the emergency room doctor, and several other key stakeholders in their town to guide their search for answers.*

*Armed with this data, they were ready to put the pieces of the puzzle together to see what still needed to be done to reach youngsters involved in the problem behaviors, to prevent others not yet engaged from becoming involved, and to identify the risk factors and assets of both groups.*

## Data Analysis

Once the initial data collection is complete, as a prevention practitioner or community specialist you will now work with other community partners and evaluators to analyze the data. This analysis will help you select the appropriate programs for your community or specific population of interest. Data analysis can also support existing policies and programs and provide justification for grant applications.

Your analysis will also identify the data that are the most compelling, as well as those that are most suitable for use as *baseline data*. This is the initial information collected prior to program implementation, against which outcomes can be compared at strategic points during and at completion of an intervention to demonstrate change.

As your analysis is unfolding, consider the following:

- Use the data to help you define the general substance abuse problem(s). The data can confirm the seriousness of a perceived problem, especially when compared to previous years. The data also may indicate if the problem appears to be more serious among certain subgroups (e.g., age groups, gender, geography, racial/ethnic background).
- Compare your data with other similar data (e.g., national, state, county, etc.). Are the trends similar? Are the rates about the same? Are they going up or down?
- Analyze what can be interpreted from the data.

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- Decide on the likely target population.
- Evaluate the relationships among the risk and protective factors for the defined population and their relative importance. What is the appropriate mix of risk and protective factors to address? Is there an identifiable "cluster" of risk factors that could be addressed together?
- Consider if the risk or protective factors can be changed. Most factors fall into one of three categories, or degrees, of changeability:

  (1) Some risk and protective factors can be completely changed. For example, academic failure can usually be remedied through tutoring and/or placement in special education classes.

  (2) Some risk and protective factors can be modified, but not changed completely. The availability of alcohol, tobacco, or illicit drugs in a community is one example. Your program might include environmental interventions to reduce the availability, but you are not likely to eradicate the problem completely.

  (3) Some risk factors can not be affected directly (or readily), such as extreme economic deprivation in a community.

- Consider associated problems you have not previously addressed in your analysis.
- Determine what assets exist in the community.

You will likely identify several critical problems during this analysis, and you will need to set priorities to determine which problems should be addressed first. There is no magic formula! Instead, you will base your criteria for prioritizing on the relative seriousness of the situation, the resources available (including the involvement of community partners), and the changeability of the factors identified.

## Use Expert Guidance When Needed

Data can be time consuming to collect and confusing to analyze. It can be difficult to decide which information is relevant and which is not. Much of the collection and analysis involves subjective decisions that are improved by specialized expertise. Given the importance of needs assessment as the foundation for all of your future efforts, it makes good sense to include someone with expertise in this area on your team.

If you need such expertise, but are short on resources, you may have to search for a creative solution. You may find the help you need at a local university or even a large teaching hospital. Invite such groups/institutions to become part of your team. If you cannot secure these services as in-kind or volunteer assistance, consider bartering for this important resource. University researchers or graduate students may be able to use your data for their own projects. Some experts may be willing to donate their time and assistance to you now if, at a later time when your funding is more secure, you are willing to contract with them for their paid services.

## Ongoing Assessment

Your needs and assets assessment should be ongoing. The initial data collected and analyzed to describe your community's substance abuse problem and to identify risk and protective factors constitute baseline data for your prevention work. They define precisely the population and the risk and protective factors that you will address. Baseline data constitute the standard, or baseline, against which you will measure all subsequent changes that occur as a result of your program(s).

As you will see in later chapters, tracking and evaluating your data is an ongoing process. It must be done to ensure that your program remains on target, that extraneous factors do not intervene, and that the outcomes are as anticipated. You may find that additional assessment will be needed along the way if subsequent evaluation does not show the expected changes when compared to the baseline data.

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# In Summary

Participating in a comprehensive needs and assets assessment process enables prevention practitioners and community collaborators to take a hard look at the underlying factors of the general substance abuse problem. This is a prerequisite for developing a responsive plan to address the problem(s).

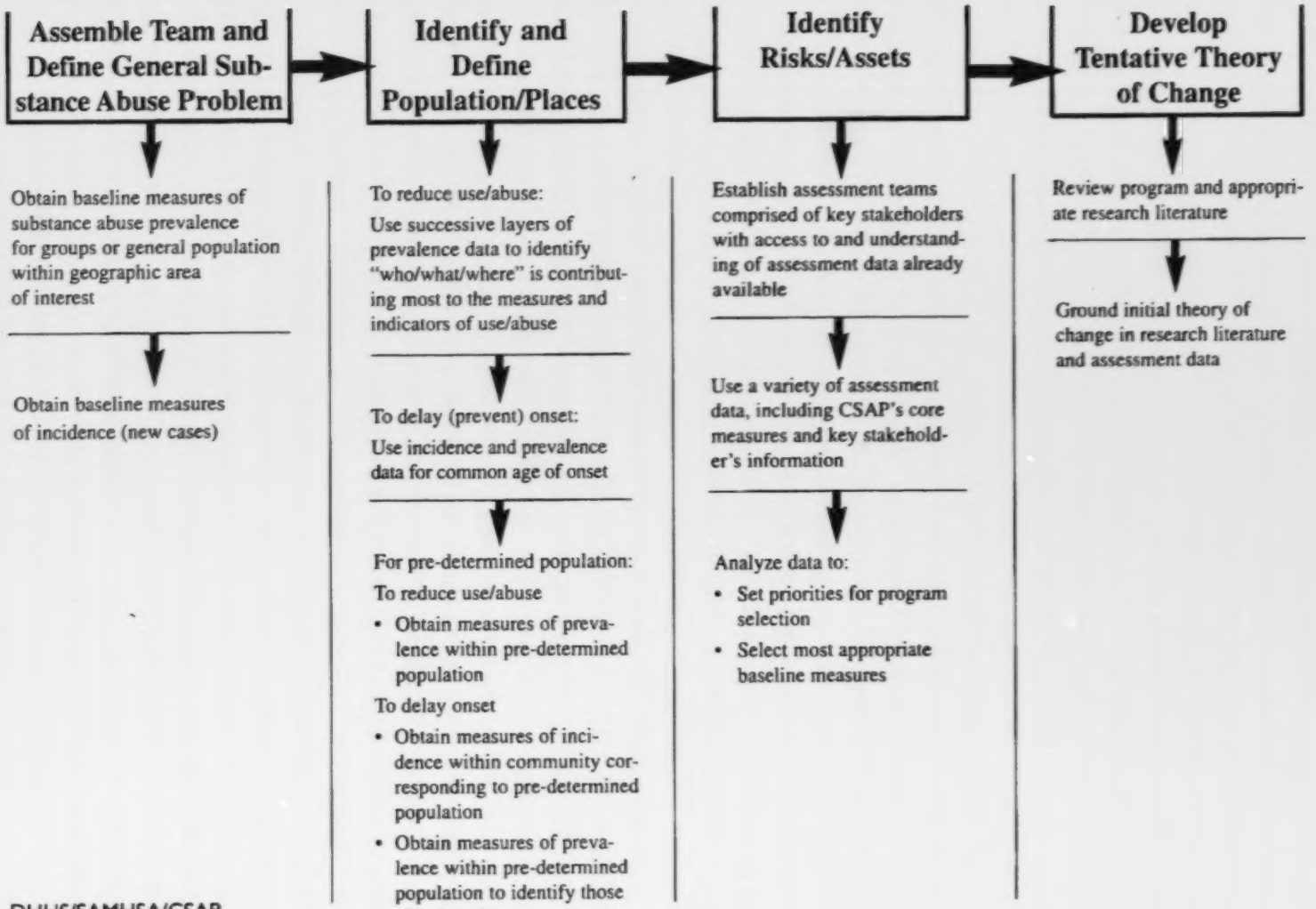
This process includes reviewing different types of data and considering the value of mounting a team effort in order to gain access to critical data, obtain data from particular sources, or explain the data you already have.

Although there is no exact formula for responding to the needs you will identify, it is important that you understand the value of utilizing someone who has expertise in assessing the information and who can provide specific guidance.

The conclusions from your analysis of the data form a framework, or conceptual map, for setting goals and objectives for your intervention and a credible theory (or theories) of change. From this theory of change you can develop a logic model to guide your work. A logic model on needs and assets assessment (figure 1.2) that summarizes the process detailed in this chapter is repeated here to help guide your work. You will find additional information about logic models and how you will use them to organize your program in chapter 4.

Once you complete your needs and assets assessment, you will be ready to tackle the steps outlined in subsequent chapters. Next steps include assessing your capacity, selecting and implementing your program, and evaluating your efforts. By the time you complete this Guide, you will see how all of these steps relate and interact in a logical way. You will be on your way to achieving outcomes.

# NEEDS/ASSETS ASSESSMENT LOGIC MODEL



# CSAP Resources

CSAP-related Web sites:

Center for Substance Abuse Prevention/National Center for the Advancement of Prevention Decision Support System: www.preventiondss.org

Centers for the Application of Prevention Technologies: www.captUS.org

Prevention Online (PREVLINE)—SAMHSA's National Clearinghouse for Alcohol and Drug Information: www.health.org

A number of useful CSAP technical assistance bulletins are available through the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847. A full list is available at www.health.org/catalog/catalognew.asp?Topic=101. See especially the Web sites for the specific bulletins listed below.

*Careful concept development paves the way to effective prevention materials.* (1994). Available: www.health.org/govpubs/MS493/

*Following specific guidelines will help you assess cultural competence in program design, application, and management.* (1994). Available: www.health.org/govpubs/MS500/

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# Chapter 2

# Build Capacity

# Introduction

Before you can effectively select a substance abuse program, it is important to examine your organization's or collaborative's capacity to bring about the changes that you would like. *Capacity* refers to the various types and levels of resources that your organization or collaborative has at its disposal to meet the implementation demands of specific interventions.

It is important that you understand the resources that will help lead you to measurable success. Resources include more than just funding. You will need sufficient funds or in-kind contributions, of course, but other resources are just as important. You will need *human resources*—staff or volunteers—with the skill sets, including leadership, program development, and networking abilities, to carry out the intended program. You will need facilities, transportation, office supplies, equipment, and other fixed capital to ensure sufficient capacity to implement sound programs. Central to your general capacity—and the area where programs often falter—you will need management and evaluation resources. You may need to seek outside resources to augment those you already have.

Specific programs—and remember that in this Guide, programs include environmental interventions—will dictate the types of capacity you will need. An absence of these resources will almost certainly jeopardize your effort. You simply will not have the tools to implement the selected prevention programs well. This may require you to select another program that meets the identified needs but requires fewer or different resources.

In this chapter, you will assess the overall capacity of your organization or collaborative to undertake your mission and assess whether the community is ready to support the program. This part of the process ensures that the required resources will be in place when needed, whether the intervention is small and very specific, or large and comprehensive.

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## Important Terms

*Capacity:* In this Guide, the various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions.

*Collaboration*: The process by which people/organizations work together to accomplish a common mission.

*Community Readiness:* In this Guide, the community's awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives.

*Cultural Competence:* The capacity of individuals to incorporate ethnic/cultural considerations into all aspects of their work relative to substance abuse prevention and reduction.

*Human Capacity/Resources:* The collective knowledge, attitudes, motivation, and skills of the program implementers and other stakeholders.

*Stakeholders:* As used in this Guide, all members of the community who have a vested interest (a stake) in the activities or outcomes of a substance abuse intervention.

## Logic Model Discussion for Capacity Building

Here again is the logic model for ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION (figure 2-1). This time, the shaded area shows how chapter 2 fits into the overall framework. Figure 2.2 shows the component logic model for chapter 2—the activities and tasks that make up the capacity building component. You will find more information about logic models and their role in achieving outcomes in chapter 4.

Figure 2.1

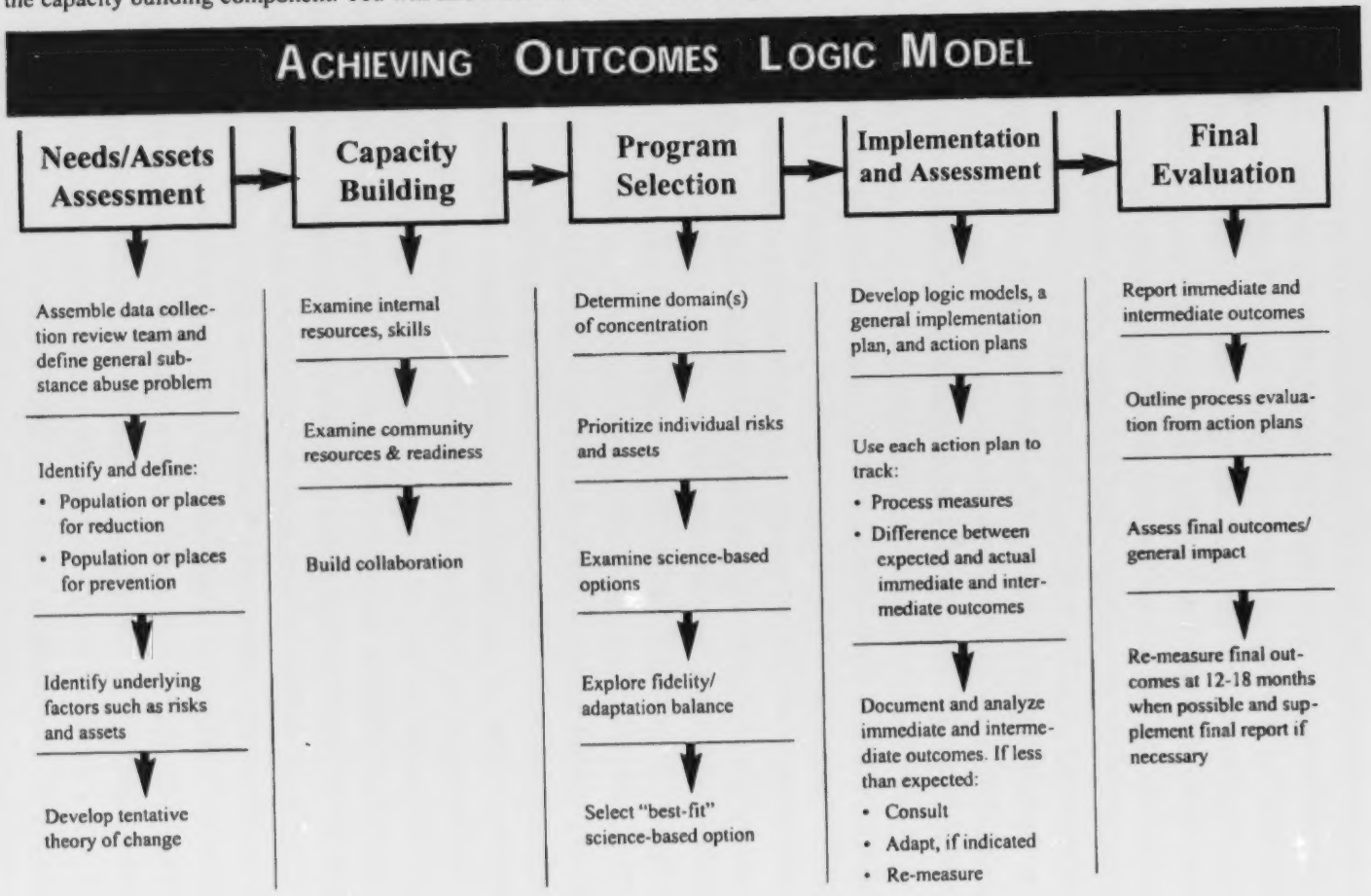


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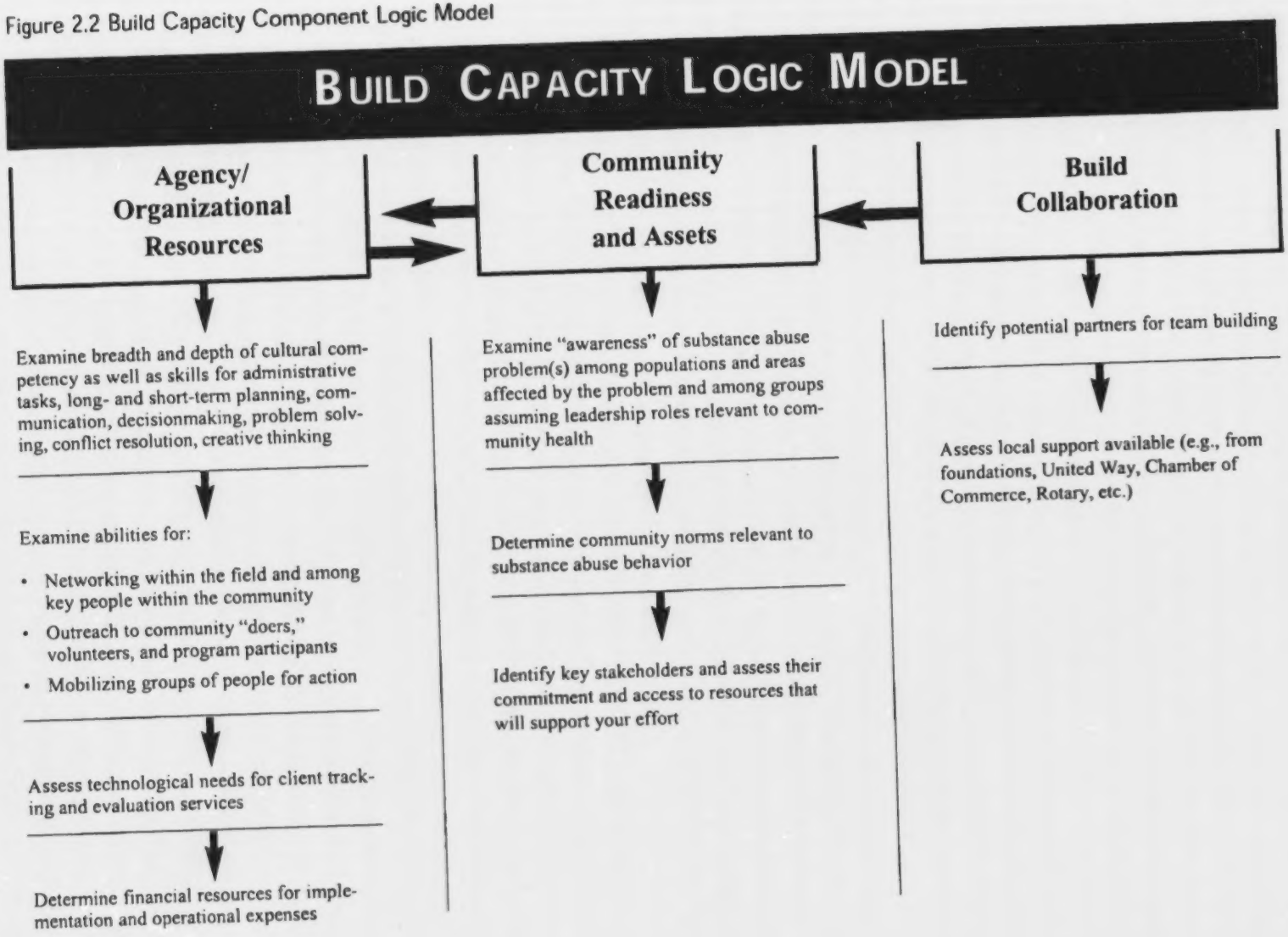
Figure 2.2 Build Capacity Component Logic Model

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# Overview

## Capacity Building Promotes Program Success

There are three steps involved in evaluating your organization's capacity—the various types and levels of resources you have at your disposal to meet the implementation demands of specific interventions:

1. Determine your internal capacity and readiness—human, technical, and financial;
2. Assess your external capacity—human, technical, and financial; and
3. Determine the readiness of your community for the selected program(s).

Assessing your areas of capacity and readiness will

- Help you make a realistic match between the needs you have identified in your needs and assets assessment (see chapter 1) and your capacity to address them;
- Provide the evidence you need to assure yourself and others that you have the ability to reach your desired outcomes;
- Reveal strengths and shortfalls in your capacity in key resource categories;
- Provide an opportunity to make up for anticipated shortfalls, find a way around them, or select another program that better matches your capacity.

### DSS Capacity Assessment Tools

The CSAP Decision Support System Web site has a series of capacity assessment and building tools in the following areas:

- Capacity Building
- Internal Capacity
- External Resources
- Strategic Plans
- Goals and Objectives
- Action Plans

## Determine Internal Capacity and Readiness

How ready and capable is your organization to carry out the proposed prevention program or initiative? There are three broad categories of resources to consider as you assess your internal capacity: human, technical, and financial.

Resources in these vital areas are central to the effective functioning and survival of any organization. They are the organization's backbone, its infrastructure.

**Human Capacity: The skill sets of the people involved in the program**

As you select your programs and activities, you need to consider the staff required and available at all levels. The staff positions needed will depend on the specific program to be implemented.

Skill sets refer to the ability to handle various functions. A leadership skill set, for instance, includes abilities in long- and short-term planning, communication, decisionmaking, and conflict resolution. Staffing should also include personnel with skill sets in the areas of communication/public relations, budgeting, fundraising, administrative support, evaluation, and project management. In a very large project, there may be a team of people carrying out these functions. In a very small project, one or two people may do it all or work collaboratively with others who are skilled in these areas.

Carefully scrutinize the credentials and abilities of the individuals who will be handling the required implementation tasks and supervision. It is important that you know what you are looking for in a staff member. You may have a number of criteria, such as the applicants' skills, their personal qualities, their commitment to or passion for your issue, and/or their demographic characteristics. You may be trying to attain a certain level of staff diversity to be representative of the population you are serving.

The following example shows what can happen when planning and assessing staff capacity are insufficient for the desired prevention initiative:

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**Example: "Insufficient Staff Capacity"**

*A well-established rural neighborhood youth club wanted to expand its service array and offer more specialized prevention programs directed at families. Having determined that many of the youths coming to the club were often engaged in conflict in their homes, the club's grant writer pursued funding for a model prevention program that encompassed family intervention strategies. The grant writer had determined that the model program met the needs of the defined population and that it had been proven successful in similar environments. However, she had not assessed the staff qualifications that were required for delivering therapeutic family programs.*

*When the club received the requested funding from its county government, it realized the deficiency in staff capacity to implement the chosen program successfully. The grant writer had only budgeted for existing staff to work in the new program, none of whom had the appropriate skill sets. The club was faced with an insufficient budget for the staff needed in the new program and the challenge of attracting an appropriately qualified staff to a rural environment.*

In this example, had the grant writer assessed the alignment between the existing staff capacity at the youth club and the staff credentials needed for the new program, she would have seen the obvious disparity between the program needs and the club's capacity. In response, she could have planned a strategy to develop and budget for the appropriate staff to execute the desired program. Alternatively, she could have selected a different program that could be implemented within the parameters of the club's existing capacity.

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## Assessing Cultural Readiness

Use this checklist to measure how prepared your organization is for multicultural work and to identify areas for improvement. If you cannot check off an item, it may indicate the need for change in that area.

- ✓ The leadership of our organization is multiracial and multicultural.
- ✓ We make special efforts to cultivate new leaders, particularly the disabled and people of color.
- ✓ Our mission, operations, and products reflect the contributions of diverse cultural and social groups.
- ✓ We are committed to equality within the organization and in our work in the community.
- ✓ Members of diverse cultural and social groups are full participants in all aspects of our organization's work.
- ✓ Speakers from any one group do not dominate meetings.
- ✓ All segments of our community are represented in decisionmaking.
- ✓ There is sensitivity and awareness regarding different religious and cultural holidays, customs, recreational preferences, and food preferences.
- ✓ We communicate clearly, and people of different culture feel comfortable sharing opinions and participating in meetings.
- ✓ We prohibit the use of stereotypes and prejudicial comments.
- ✓ Ethnic, racial, and sexual slurs or jokes are not tolerated.

Adapted from *Community Toolbox*. Cultural competence in a multicultural world.

**Capacity for Cultural Competence**

Culturally sensitive and responsive prevention programs are important. The capacity of individuals to incorporate ethnic/cultural considerations into all aspects of their work relative to substance abuse prevention and reduction is called *cultural competence*.

Here are the kinds of questions to ask in assessing your organization's or collaborative's cultural competence: Does the organization continuously strive to build cultural competence within its staff? Do you encourage development of academic and interpersonal skills that allow personnel to increase their understanding and appreciation of cultural differences and similarities in others? Is the staff representative of the defined population? Is staff willing and able to draw on community-based values, traditions, and customs? Is the staff willing and able to work with knowledgeable persons from the community in developing tailored programs and other supports?

A commitment to cultural competence encompasses the following:

- Acknowledging that cultural differences exist and have an impact on the delivery of substance abuse prevention programs.
- Respecting the culturally defined needs of the population, including the complexities of multiple cultures. People are rarely defined by one culture. The culture of poverty, for example, influences values and behaviors just as race and ethnicity do.
- Recognizing that the number of people who describe themselves as biracial or multiracial is increasing rapidly. This challenges many past assumptions about specific approaches tailored to race, ethnicity, or culture. While there is no easy answer, having the capacity as an organization or collaborative to understand, be respectful of, and respond to evolving diversity is an important quality.
- Understanding that people from different racial and ethnic groups

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and other cultural subgroups are usually best served by persons who are a part of or in tune with those cultures.

- Recognizing that embracing cultural diversity enhances the capacity of all.

Building culturally competent organizations means changing how people think about other cultures and how they communicate. It also means that the structure, leadership, activities, and messages of an organization must reflect many perspectives, styles, and priorities.

**Technical Capacity: Specialized support that sustains an organization**

Depending on the size and scope of your organization or collaborative and your planned program, you may need technical capacity not regularly available. This includes managerial, administrative, or specialized support, such as evaluation skills, to carry out your particular prevention efforts. You may need this specialized expertise only intermittently and not on a full-time basis. Other community groups, agencies, and businesses may have resources to provide support for your prevention initiative(s).

- Managerial support maintains information on all activities and their outcomes; establishes protocols for allocating resources; and institutes strategies for working with staff and volunteers. Your program or collaborative may not need a sophisticated management information system (MIS); a simple tracking system (even non-computerized) may be adequate for a small operation. Your region's Center for the Application of Prevention Technologies (CAPT) can help tailor tracking and management solutions to your needs. (For more information about the CAPTs, go to www.captUS.org.)
- Administrative support represents facility management, communications, operations, and logistics (e.g., phones, faxes, databases, and the Internet; training and human development; and office tasks, such as keyboarding, filing, and preparing reports). Business activities, including bookkeeping, payroll, purchasing, and accounting, also fall under administrative support. The New York Foundation for the Arts has created a handy technology assessment tool for the nonprofit sector to help assess needs in this area (see resources section for how to access this tool online).
- Specialized support refers to the kinds of infrastructure you may need for a particular program, such as desktop publishing or large event planning and production. Specialized support can also refer to your need for expert professional evaluation assistance, as will be described in chapter 5.

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**Financial Capacity: The ability to leverage funding to implement desired programs**

Inadequate funding is often a reason why prevention efforts fail. Funding capacity relates to assessing the costs of implementing the proposed program and determining how to make up deficits through donations or by leveraging resources. Most important, it means developing a long-term funding strategy that ensures sustainability.

Here are some ways to improve your funding capacity:

- Use networking skills to keep informed and to develop connections with others.
- Appoint someone in your organization or collaborative to track funding opportunities that might be available.
- Seek out a local professional with grant writing and content area expertise to review your proposal, even if you cannot afford to hire a resource developer/grant writer. Guidance on grant writing and resource development is widely available. See this chapter's resources section for leads to helpful publications and Web sites.
- Find a like-minded tax-exempt organization to apply for a grant on your behalf. That same group, often called a "lead agency," might also manage the grant funds you receive.
- Stay connected with potential funding sources and have action plans already developed so you can move quickly when an opportunity comes your way. Funding success often means being in the right place at the right time.
- Get to know your local political leaders so that they return your calls; make sure that they and other key stakeholders understand the importance of your issues.
- Diversify your funding so you will not be dependent on a single source of support.
- Stick to opportunities that are consistent with your mission. This will prevent internal and external confusion about your program identity and help create a local base of support.
- Coordinate grant applications within a collaborative or partnership to take advantage of several funding streams for the various components of your prevention efforts.

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Few grant awards are large enough to fund development, implementation, and proper evaluation of a program. You must be prepared to leverage grant money and other resources so that the prevention effort does not falter in its implementation cycle, or when the initial grant is finished.

Your organization or collaborative should have a development unit or committee responsible for identifying and pursuing funding opportunities. This is often a role for a board and management team. Internally, the organization also needs to have skilled staff to manage and report on financial matters.

**Example: "Financial Capacity Considerations"**

*The Teen Development Program is an effective parent-training program developed for intervention with at-risk teens. However, it requires a highly qualified leader for every 15 families to conduct weekly group sessions, individual family meetings, and mid-week supportive phone calls. In addition, the program recommends a parent consultant to facilitate the group process and parent participation. Also, parent incentives (such as dinners, movies, bowling), child care, and meeting snacks add to the expense, although they also improve the level of participation. Training is required either onsite or at a nearby community center. Selecting the onsite training option adds $500 per day to the training costs. There are also expenses involved in purchasing a leader's guide and workbooks.*

In short, there are financial considerations for nearly all programs and interventions. Some programs may simply be beyond the financial capacity of an organization to implement, even if they are appropriate to the group's objectives.

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Figure 2.3 Guide for Internal Capacity Assessment

| | |
|---|---|
| Assess the strengths and weaknesses of **strategic leadership** within the organization or collaborative: | • Leadership (managing culture; setting direction; supporting resource development; ensuring tasks are done)<br>• Strategic planning (scanning environment; developing tactics to attain objectives, goals, mission)<br>• Governance (legal framework, decisionmaking process, methods for setting direction, external links)<br>• Structure (roles and responsibilities, coordinating systems, authority systems, accountability systems) |
| Assess the strengths and weaknesses of the following **systems, processes, or dimensions of human resources** (managerial, direct service, technical/support staff): | • Human resource planning (recruiting, selecting, orientation)<br>• Training and professional development (performance management, monitoring, and evaluation)<br>• Career management (record keeping, merit)<br>• Compensation (wage rates, incentives)<br>• Equity (gender, minority issues) |
| Assess the strengths and weaknesses of other **core resources**: | • Infrastructure (facilities, equipment, maintenance systems, utilities)<br>• Technology (information, communication technologies, levels of technology needed/acquired to perform work)<br>• Finance (planning, managing and monitoring cash flow and budget, ensuring an accountable and auditable financial system) |
| Assess the strengths and weaknesses of **program management** within the organization: | • Planning (identifying needs, setting objectives, costing alternatives, and developing evaluation systems)<br>• Implementing (adherence to schedules, coordination of activities)<br>• Monitoring (systems for evaluating progress, communicating feedback to stakeholders) |
| Assess the strengths and weaknesses of **process management** within the organization: | • Planning (identifying needs; looking at alternatives, setting objectives and priorities, costing activities, and developing evaluation systems)<br>• Problem-solving and decisionmaking (defining problems, gathering data, creating alternatives, deciding on solutions, monitoring decisions)<br>• Communications (exchanging information, achieving shared understanding among organizational members)<br>• Monitoring and evaluating (generating data; tracking progress; making judgments about performance; utilizing information; changing and improving organization, program, etc.) |

Adapted from Lusthaus, Anderson, and Murphy, 1995.

## Assess External Capacity

The same three key capacity areas—human, technical, and financial—also need to be examined as they relate to resources outside your organization. As noted previously, you need to consider diverse funding streams external to your organization. These include local funding initiatives, such as individual donations and direct local support from government entities or other organizations; regional and Federal initiatives, such as state block grants and state and Federal grant programs; and foundation support.

External support from volunteers can also add value to your prevention efforts. Most nonprofit organizations rely on volunteers to varying degrees. The jobs done by volunteers are as varied as the people who do them. For example, a volunteer might be a high school student who provides tutoring assistance to younger children, an accountant who helps the director apply for tax-exempt status, or a retired city commissioner who has an interest in the community's anti-drug efforts. Regardless of the actual tasks they do, volunteer contributions in terms of time, energy, skills, and other resources are critical for an agency's (or program's) success. The involvement of volunteers in your organization directly and through collaboration partners can expand your program's constituency and network of support.

Physical resources also enhance your organization's capacity. For example, schools or faith community buildings may provide space for afterschool programs, while the community library may donate meeting space for prevention-related classes or board meetings. Other agencies and businesses may offer the use of vehicles, computers, or other equipment. Creative use of your community's physical resources can reduce expenditures and increase access to prevention services.

**Assessing Overall Community Readiness**

Assessing your internal readiness as an organization/collaborative and the external resources available for your initiative are important steps. But you must also consider whether the community, schools, or neighborhood groups are ready to accept your prevention effort.

Research and experience over the past decade show that communities vary in their level of readiness to implement a prevention program. *Community readiness* refers to a community's awareness of, interest in, and ability and willingness to initiate and support substance abuse prevention efforts.

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The degree of readiness within a community can be viewed as a stage in which prevention efforts can be either facilitated or thwarted. There are nine stages of readiness (see figure 2.4), according to Edwards et al. (2000). The National Institute on Drug Abuse (NIDA) found similar factors to be associated with a community's readiness for prevention programming.

You must consider community readiness for program effectiveness. Enduring, coordinated, and comprehensive prevention efforts are more likely to have the desired impact when there is community buy-in, and that occurs only when community readiness is present.

You need to ensure that *stakeholders*—individuals or groups in the community who have a vested interest in the success or failure of your efforts—are involved in your program. They are vital to enhancing the credibility needed by your organization or collaborative to function successfully. And, as noted earlier, they bring essential external resources to the table. The higher the level of community buy-in, the more sustainable your effort will be over time.

These stakeholders should be as diverse as the population you plan to serve. Include representatives of every sector of the community—government, law enforcement, and schools; people most affected by the program you are planning; diverse cultural, social, and faith community groups; business leaders and other people with influence in the community; and people in control of resources or who have access to resources needed by your effort. Key stakeholders might include the police chief, business leaders, a number of minority associations such as the NAACP, the mayor, and many others.

As you will see in the next section, how you involve these stakeholders and how extensively you broaden community representation in your intervention will vary with the scope of your organization and the program you select.

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Figure 2.4 Stages of Community Readiness

**Stage 1: Community Tolerance** – Norms tolerate or encourage the behavior.

**Stage 2: Denial** – There is little or no recognition of the evident problems.

**Stage 3: Vague Awareness** – There is a general belief that a problem exists, but awareness is only linked to one or two incidents.

**Stage 4: Preplanning** – There is recognition of the problem, and leaders are identifiable; but there is little planning about how to address problems and risk factors.

**Stage 5: Preparation** – Planning is going on and focuses on practical details. Funding is being sought by the active leaders.

**Stage 6: Initiation** – Enough information is available to justify a prevention program. Great enthusiasm exists as program begins.

**Stage 7: Institutionalization** – More that one prevention program is running with support and with trained staff. There may not be permanent funding.

**Stage 8: Confirmation/Expansion** – Standard programs are viewed as valuable; new programs are being developed in order to reach out to the populations more at-risk. Evaluation of efforts is regular and more sophisticated.

**Stage 9: Professionalism** – Detailed and sophisticated knowledge of prevalence, risk factors, and program effectiveness exists. Programming is tailored to meet special needs and risk factors. Staff is highly trained.

From Edwards, Jumper-Thurman, Plesred, Oetting, and Swanson, 2000.

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## Team Building

Depending on the scope of your prevention effort and the size of your organization or collaborative, you may now want to take a look at building a team for implementing the prevention program. This implementation team may be different from the one you assembled for needs and assets assessment.

Your team will consist of those individuals who have a vested interest in the specific problem or, more generally, in the prevention and treatment of substance abuse. Parents are an obvious link. Others include the faith community, the media, school personnel, health professionals and public health organizations, social service agencies, law enforcement,and elected officials.

Obviously, the scope of the program you select determines how much of the greater community should be involved and to what degree. For a comprehensive program, you might include representatives from the following groups:

- youth
- parents
- business community
- media
- schools:public and private
- youth-serving organizations
- institutions of higher learning
- law enforcement agencies
- religious or fraternal organizations
- civic and volunteer groups
- healthcare professionals
- state, local,or tribal governmental agencies

## Teaming: Capacity Building Through Networking and Collaboration

Prevention practitioners increasingly realize they must adopt comprehensive, interrelated approaches to prevention to deal with the multiple and interrelated factors that contribute to substance use/abuse. You, too, may find that you need to expand your individual capacity by joining with others.

*Collaboration* is the process by which several agencies or organizations make a commitment to work together to accomplish a common mission. It has the effect of capitalizing on each other's program and administrative strengths, such as sharing technical assistance from specialized experts or working together to mobilize additional funding and community volunteers.

Here are some of the possible benefits of collaboration:

- Simplifying or enhancing the needs and assets assessment process;
- Identifying gaps in current services and working together to fill those gaps;
- Expanding available services by cooperative programming;
- Providing better services through interagency communication about participant needs;
- Sharing similar concerns while being enriched by the diverse perspectives that members from various backgrounds bring to the collaboration;
- Reducing competition for addressing issues;
- Improving communication with organizations within the community and through those organizations to larger segments of the community;
- Mobilizing to effect needed changes through collective advocacy;
- Achieving greater visibility with decisionmakers, the media, and the community;
- Enhancing staff skill levels by sharing information and organizing joint training programs;
- Conserving resources by eliminating duplication of efforts.

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**Example: "Capacity Building"**

*Ward 6 is a poor, inner-city neighborhood with one of the highest rates of unemployment and crime, substandard housing, low educational achievement, drug-related arrests, and single-headed (mostly female) families. Community leaders Patricia Salazar and her husband were concerned about these problems and, in particular, concerned for the overburdened mothers. They determined that classes in parenting skills offered at night, after working hours, would be a good beginning to improve the environment for children.*

*The parenting classes were very well received and attended. However, through discussions with the mothers, the Salazars realized the community needed to address another significant need. Many of the elementary school age children and most of the middle school age youngsters in their neighborhood are latchkey children—usually on the streets without supervision after school hours. This places them at greater risk of negative influence from peers, older students, and others who might promote their use of alcohol, tobacco, and illicit drugs.*

*The Salazars did not have the capacity to address this problem by themselves. Building upon established relationships with some community leaders and forging new partnerships with other community service providers, they were able to create a comprehensive afterschool program for these neighborhood youth. The partnerships included the following: connecting with a local church that had a van that was not used on weekday afternoons; recruiting retired people in the community to drive the van to the middle school each day to pick up students and transport them to Casa Unido, the local community center; arranging for high school honor students to tutor and help with homework as part of their required community service hours; obtaining donations of a ping-pong table and basketball equipment; and arranging for sports enthusiasts to supervise recreation. They were even able to acquire insurance coverage for the volunteer drivers and the van, through a donation from a local insurance company.*

This kind of collaboration is part of capacity building. It worked particularly well because each partner's contribution suited its own individual purposes or interests.

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The team or collaborative brings various perspectives to determining your program. You may choose to address an easier problem in order to build community support around a successful undertaking. Or, you may want to tackle a more complex, multiple-problem intervention that will take full advantage of the resources and partners already in place. In all cases, the community should be solidly behind the criteria and the approach adopted.

If the team decides to tackle a problem that is less urgent, but potentially more reasonable under the circumstances, you should not forget the larger problem. It can be addressed by others who have the capacity to do it sooner, or it can be established as a long-term goal to be tackled by your team at a later date.

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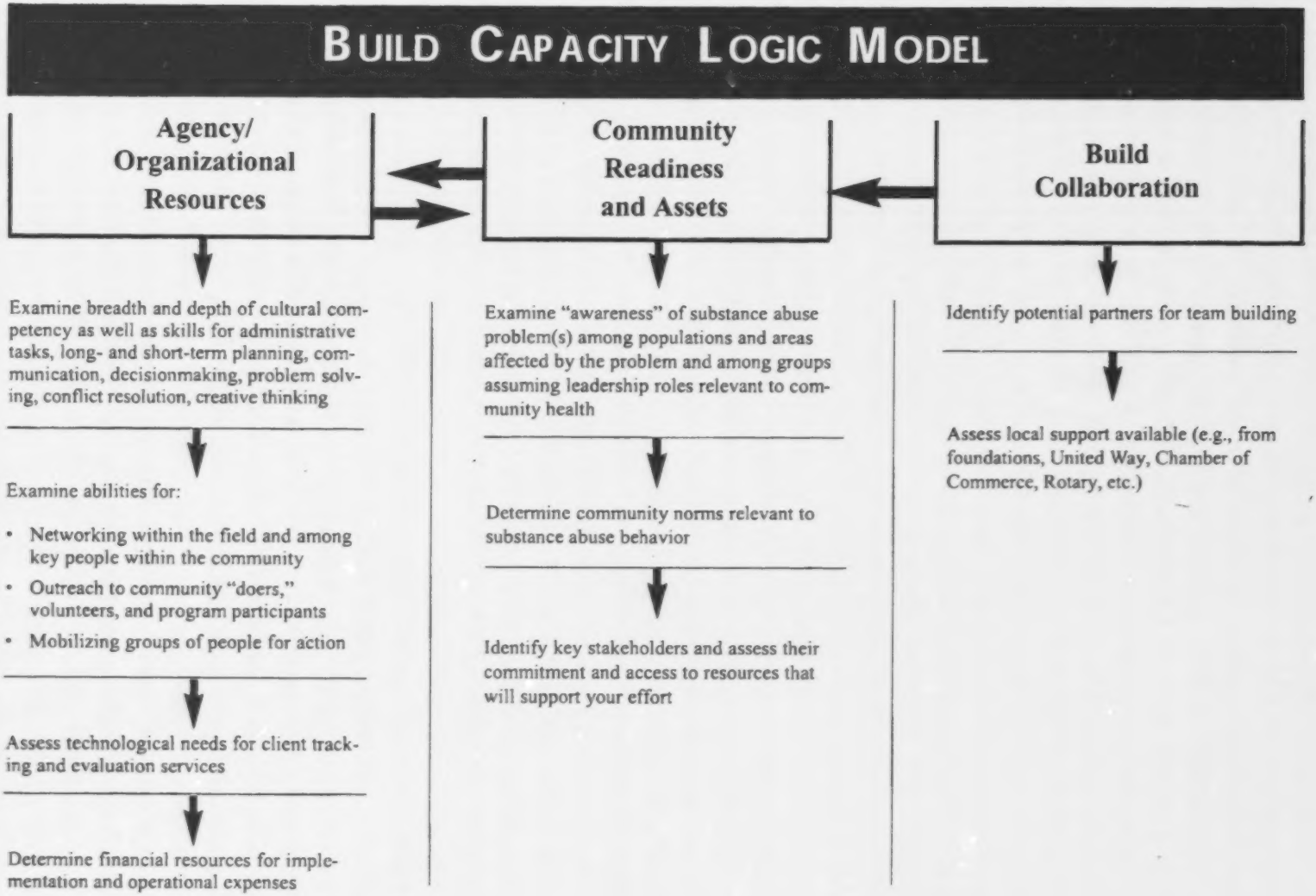
# In Summary

Effective and sustainable prevention efforts must be based on adequate internal and external resources at the organization or collaborative level. Moreover, your prevention programs can be successful only if developed within the context of community readiness for substance abuse prevention. Achieving that community readiness often depends on involving key stakeholders in your efforts.

There are a variety of tools available to help prevention practitioners assess capacity and readiness (see resources section). Once you know your existing internal and external assets, you can then direct your efforts toward increasing readiness and building capacity as needed. The "Guide for Internal Capacity Assessment" in figure 2.3 provides additional considerations for assessing organizational capacity.

Reviewing figure 2.2 (presented again on the following page) will remind you of the importance of developing capacity in the overall ACHIEVING OUTCOMES process. This will help you determine if you have all of the resources you need to make an informed selection of a prevention program or practice—the next step toward achieving outcomes, to be discussed in chapter 3.

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# Resources and References

Area Health Education Center (AHEC) Network offers community/coalition building resources at: www.ahecpartners.org/resources/cb/

Arts Wire SpiderSchool at New York Foundation for the Arts (NYFA) provides information and training for nonprofits on how to integrate technology into their work. A technology assessment tool is available at: www.artswire.org/spiderschool/workshops/planning/inventory.html

Community Anti-Drug Coalitions of America offers technical assistance, media strategies, and coalition development: www.cadca.org

*Community Toolbox* is a Web site (http://ctb.lsi.ukans.edu/) created and maintained by the University of Kansas Work Group on Health Promotion and Community Development in Lawrence, KS, and AHEC/Community Partners in Amherst, MA. The site provides "how-to tools" as well as links to hundreds of other Web pages and listservs in areas such as funding, health, education, and community issues. See especially Part H, chapter 27: Cultural competence in a multicultural world. Retrieved Nov. 28, 2001, at: http://ctb.lsi.ukans.edu/tools/EN/chapter_1027.htm

Edwards, R.W., Jumper-Thurman, P., Plesred, B.A., Oetting, E.R., & Swanson, L. (May 2000). Community readiness: Research to practice. *Journal of Community Psychology, 3*.

The Foundation Center provides education and training on the grant seeking process: www.fdncenter.org/#

Lusthaus, C., Anderson, G., & Murphy, E. (1995) *Institutional assessment: A framework for strengthening organizational capacity for IDRC's research partners.* Ottawa: International Development Research Centre.

National Center for Service Integration. *A matter of commitment: Community collaboration guidebook series* [Online series of 14 commissioned guidebooks on essential components of comprehensive community reforms]. See especially:

- Guidebook 2: Defining the prize: From agreed-upon outcomes to results-based accountability. Retrieved Nov. 28, 2001, at: www.cfpciowa.org/pdf/GB2DefiningthePrize.pdf
- Guidebook 3: Valuing diversity and practicing inclusion: Core aspects of collaborative work. Retrieved Nov. 28, 2001, at: www.cfpciowa.org/npnpvdABS.shtml

National Clearinghouse for Alcohol and Drug Information offers resources on multiculturalism: www.health.org/catalog/catalog.asp?pop=12

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# Chapter 3

## Select Programs

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# Introduction

Your chances for achieving positive outcomes will increase if you select from among the many science-based programs currently available. Your best choice is a program that has been designated by CSAP as "promising," "effective," or "model" (See figure 3.3). Remember, in this Guide, programs include environmental interventions.

*Science-based programs* are best because they have demonstrated positive outcomes and, especially if they are effective or model programs, these outcomes are consistently positive and reliable over time. This is important to funders, your community, and the field as a whole. However, a preference for science-based programs should not discourage program developers and practitioners from innovation. Their job in documenting outcomes may be more difficult, but they also will have contributed to the field with new approaches and new ideas.

All science-based programs are theory-driven and include activities that are related to that theory (See chapter 1 for a discussion on developing an initial theory (or theories) of change that is appropriate for your defined population). It is important that your approach is plausible (a review of the literature will help you reach this stage), and that you understand that you may need to refine your initial theory of change as you narrow your program choices.

The importance of science-based programs is now widely acknowledged in the prevention field. To optimize opportunities for achieving positive outcomes, CSAP has created a National Registry of Effective Prevention Programs (NREPP). NREPP's mission is to identify, review, and disseminate effective prevention programs. Science-based programs rated by NREPP fall along a continuum of effectiveness, ranging from promising to model programs.

*Promising programs*, the first category on the continuum, have demonstrated some positive outcomes, but either these are not consistent over time, or the evaluation has not yet been rigorous enough to show consistency. *Effective programs* have demonstrated a consistent pattern of positive outcomes. *Model*

## Program Selection

- Examine what science-based programs address the theory, or theories, of change suggested by your needs assessment data.
- Determine how the results of the science-based program you are considering fit your goals, objectives,culture, and characteristics of the population to be served.
- Assess the resources you will need (human, technical, and financial).
- Repeat this process for all programs you are considering, so you can compare pros and cons.
- Make the selection.

*programs* have consistent outcomes and are readily available for dissemination, with technical assistance available from program developers. These programs are assembled into a CSAP report, titled "Annual Report of Science-Based Prevention Programs." They are also available online at www.modelprograms.samhsa.gov/.

This chapter outlines how you will use your initial theory, or theories, of change to select a program, taking into account cultural fit, your organization's capacity, and community awareness issues. Even if your program was pre-selected because of funding mandates or other requirements, you should still familiarize yourself with the contents of this chapter. The discussions of program criteria and fidelity and adaptation, in particular, will enhance your ability to implement a successful program.

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## Important Terms

*Adaptation:* Modification made to a chosen intervention (e.g., qualitative and/or quantitative changes to components); changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when (a) underlying program theory is understood; (b) core program components have been identified; and (c) both the community and needs of the population of interest have been carefully defined.

*Core Components:* Program elements that are demonstrably essential to achieving positive outcomes.

*Effective Program:* In CSAP's terminology, an intervention that builds upon established theory, comprises elements and activities grounded in that theory, demonstrates practical utility for the prevention field, has been well implemented and well evaluated, and has produced a consistent pattern of positive outcomes.

*Fidelity:* On a continuum of high to low, where high represents the closest adherence to the developer's design, the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a given organizational or community setting. In operational terms, the rigor with which an intervention adheres to the developer's model.

*Model Program:* In CSAP's terminology, model programs have all of the positive characteristics of effective programs with the added benefit that program developers have agreed to participate in CSAP-sponsored training, technical assistance, and dissemination efforts.

*Promising Program:* In CSAP's terminology, the first of three categories of science-based programs on a continuum that concludes with model programs. Promising programs are those that have been reasonably well evaluated, but the positive findings are not yet consistent enough, or the evaluation not yet rigorous enough, for the program to qualify as an effective program.

*Science-Based Program:* A program that is theory-driven, has activities related to theory, and has been reasonably well implemented and well evaluated.

## Logic Model Discussion for Program Selection

The program logic model below, figure 3.1, shows how chapter 3 (the shaded area) fits into the overall framework of ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION. Chapter 3 is organized around activities and tasks that make up its component logic model, as depicted in figure 3.2. Chapter 4 provides more information about logic models and their role in achieving outcomes.

Figure 3.1

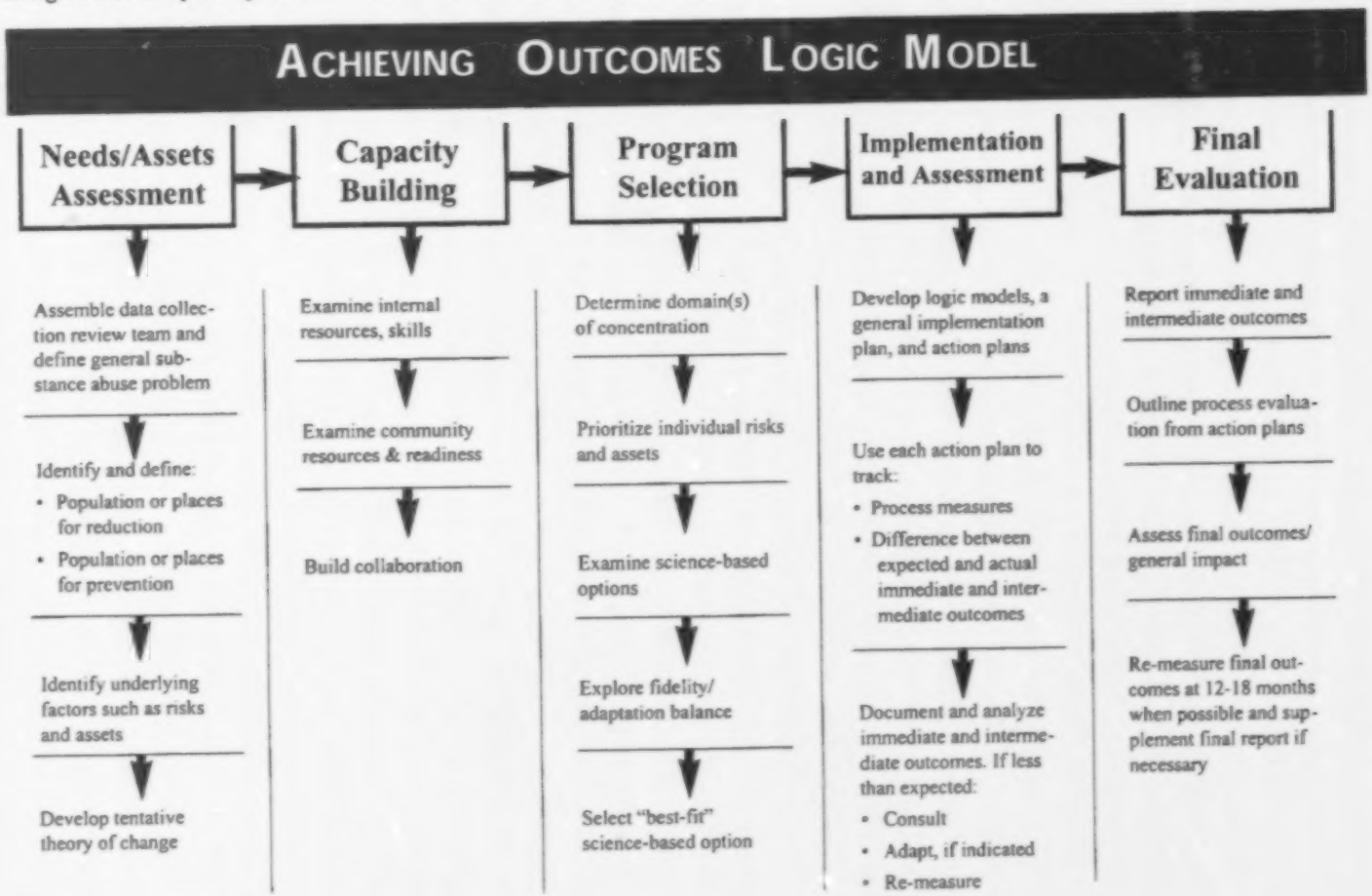


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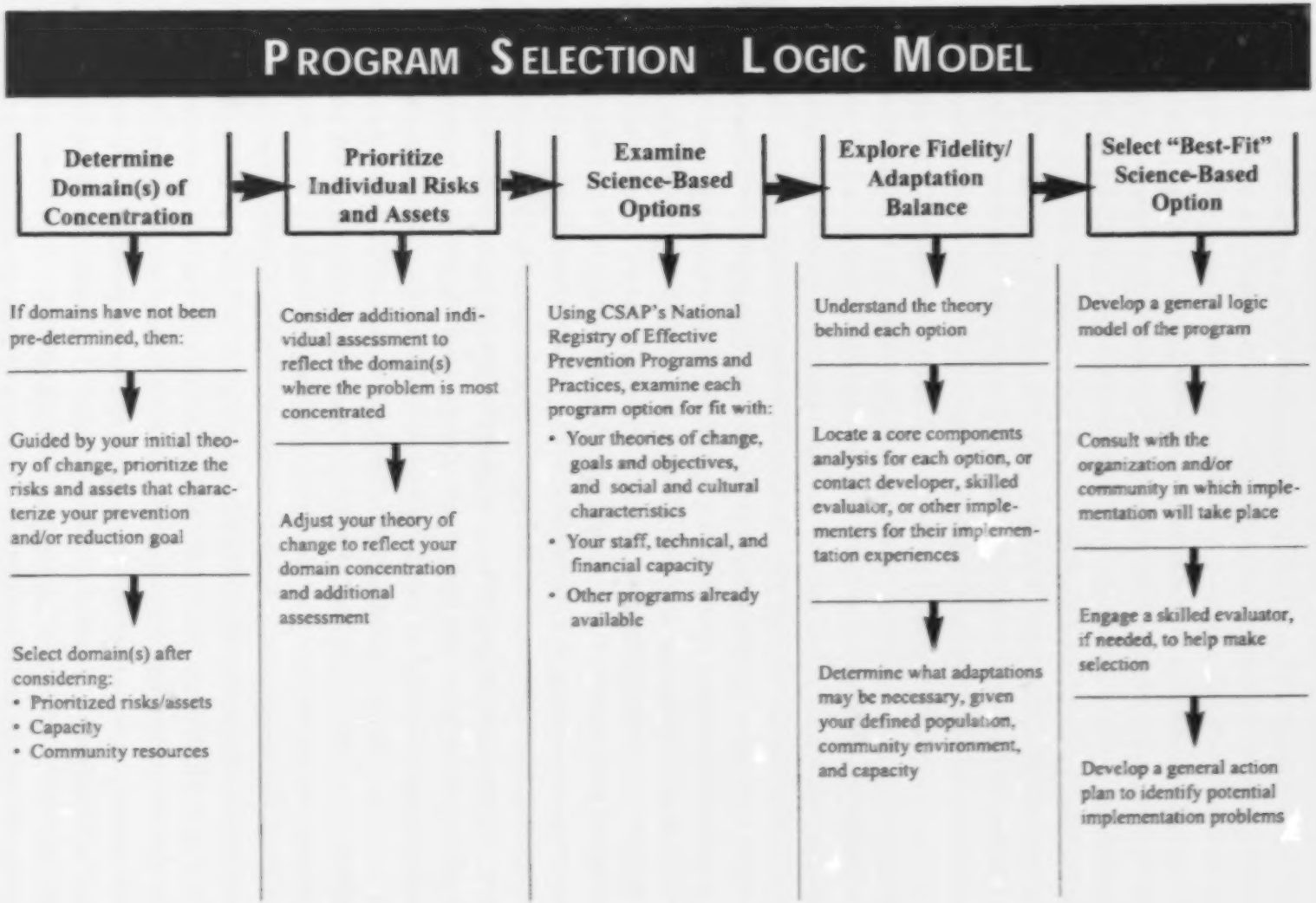
Figure 3.2: Program Selection Component Logic Model



# Overview

## Steps to Facilitate Selecting a Program or Intervention

As described in chapter 1, you will establish a theory (or theories) that explains the relationship(s) among the underlying risks and assets of your defined population or geographic area of interest and how those factors or conditions contribute to the general substance abuse problem. You are now ready to select a program that addresses them.

You may not find a program that matches your situation precisely. If that is the case, you may need a skilled evaluator to help you determine which program can be adapted most successfully to fit your needs without jeopardizing the components that account for its effectiveness. This is the process of balancing fidelity and adaptation.

The following steps will facilitate your program selection as you examine the science-based program options:

1. Examine which science-based programs address the underlying conditions suggested by your needs and assets assessment data. The resources section at the end of this chapter includes information to help you identify potential programs.
2. Determine how the theory and outcomes of the science-based program you are considering fit your underlying conditions. Its final outcomes should match your goal(s); the immediate and intermediate outcomes should closely match your objectives.
3. Focus your selection on programs that fit your capacity, goals, and objectives.
4. Make sure that your choices reflect the characteristics of the population and community to be served. Not every science-based program will fit the cultural characteristics of your community.

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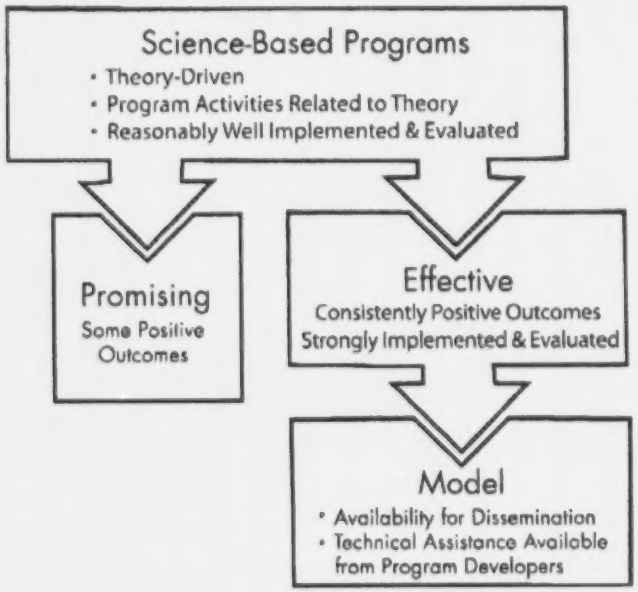
5. Contact other groups that have implemented the initiative for information about their experiences. The program developer can help you locate these groups.
6. Assess the resources you will need. Review chapter 2 to help determine if your capacity—human, technical, and financial—matches the requirements of the program you hope to implement. Costs of the proposed program or implementation resources beyond your capacity will suggest bypassing that program in favor of another.
7. Repeat this process for other programs you have identified as potentially viable for your needs. You can then compare their pros and cons.
8. Working with a skilled evaluator, make the selection. Amend your theory of change if necessary (and appropriate) to facilitate selection.

Figure 3.3




Substance abuse prevention has evolved considerably in recent years. It is now possible to select prevention programs that address specific populations, specific risks, and specific outcomes. The foundation of prevention is science-based knowledge—knowledge that has been studied, tested, or researched in a standardized way. Programs and interventions that are science-based are theory-based. This means that they are grounded in well-developed concepts about how and why the intervention should work. They have been reasonably well evaluated, so you can rely on their effectiveness.

As illustrated in figure 3.3, *science-based programs* that show some positive outcomes, but that are not consistent over time, are called promising programs. The more proven science-based programs—because they produce consistently positive outcomes—are defined as effective programs. Effective programs that are available for dissemination and provide access to technical assistance through the program developer are known as model programs. Selecting a model program, if one is appropriate or can be adapted to your defined population and its risk and protective factors (reflected in your theory of change), is always preferable.

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As shown in figure 3.4, some characteristics of science-based programs might be considered to be constraints. However, the pluses usually outweigh the minuses because of the program's reliability for producing the desired outcomes. Of the three categories of science-based programs, clearly those deemed effective or model are preferable.

But what if you cannot find an effective or model science-based program to meet your needs or specific objective(s)? In such a case, you might consider selecting a promising program. If you do select a promising program rather than an effective or model program, using the ACHIEVING OUTCOMES process to document your outcomes could help the field move promising programs closer to "effective" status.

If you have a choice, however, it is better to choose programs that have been successfully replicated across venues and populations. Programs that are in earlier stages of replication may be more difficult to assess in terms of clear outcomes. And, while needed to advance the field, demonstrating positive outcomes for promising programs, compared to those that have already been rigorously evaluated, increases your evaluation burden.

Figure 3.4

There are pluses and minuses to science-based programs

| PLUSES: | MINUSES: |
|---|---|
| Science-based initiatives are more likely to work than programs based upon unverified practices. | Science-based initiatives may be difficult to implement with fidelity. |
| Such initiatives are more likely to be viewed favorably by Government funding sources. | Science-based initiatives may be more costly to implement initially, because many developers of these programs charge fees for materials and program use. |
| Generally there is experienced help available from others who have successfully implemented the initiative. | Science-based initiatives often require a well-trained and experienced staff. |
| Science-based initiatives have a documented research base and a track record; thus, they are easier to evaluate. | Adapting science-based initiatives to local needs requires careful attention to the core components, those program elements that are essential to achieving positive outcomes. |

## Determine Domains of Concentration

As discussed in chapter 1, your informed and plausible assumptions about how and why the desired change(s) will most likely occur are known as your theory (or theories) of change. Once you have established a theory to explain the relationship among the underlying conditions that characterize your defined population, place, or policy and how they contribute to the substance abuse problem, you can examine program(s) to address those specific factors.

Chances are that your theory, or theories, of change encompass(es) risks and assets from several of the six domains discussed in chapter 1. Current research indicates that the most successful prevention efforts are those that work across multiple life domains, as represented by social institutions such as family and the community, or that are part of a comprehensive approach that includes program components from more than one domain.

This comprehensive approach is easier for a collaborative than for an individual organization or agency. Having several collaboration partners with track records in different domains makes it possible to probe for a more comprehensive picture of the risks and assets you will be addressing as you refine your theory, or theories, of change. Such a partnership also enables you to approach several domains simultaneously during the selection and implementation phases.

If, however, you are not in a formally organized collaborative, it may be wise to focus your prevention effort on only one or two domains at a time. How will you make an informed choice of which domains? Here are three factors to consider:

1. The priorities among the risks and assets that have been identified for your defined population;
2. Your capacity to work effectively within the domain(s) suggested by the prioritized risks and assets; and
3. Your assessment about the domain(s) in which (given staff and financial capacity) you are most likely to produce the desired change.

Think back to example A in chapter 1 about the middle school boys who were substance abusers and who shared a range of risk factors—poor school performance, dysfunctional family life, and negative peer influences. Which of these factors should be the focus of the program?

If you are not part of a formally organized collaborative, perhaps your theory (or theories) of change already expresses your choice. You have likely selected the domain that reflects your prior experience and capacity, and you have developed your theory or theories of change accordingly.

**Example: "Unidos Family Life Center"**

*The Unidos Family Life Center has been working successfully with families struggling with the effects of alcohol abuse. The Life Center worked with school administrators to identify which of the middle school boys were members of the Life Center families. The Life Center team recognized that school performance was certainly an important domain to address, but that was beyond the Life Center's capacity. The Life Center team chose to stay in its area of expertise—the family domain. The Center expanded its involvement with families, using its best outreach efforts to include the families of all the middle school boys involved in the troublesome behavior, as well as the middle school children of other Life Center participants. The Life Center also established closer ties to the county collaborative. Although Life Center staff chose not to affiliate with the collaborative, they recognized that reciprocal information sharing and referrals might help both the collaborative and the Center fulfill their missions.*

Consider, on the other hand, that you are part of an afterschool initiative that has focused successfully on positive youth development. As a concerned community group, you, too, wish to be helpful to these middle school boys. The family domain holds no promise for you at this time, but you have had considerable success with an afterschool citizenship development program for young people in grades six through nine. Some of your success comes from the hands-on, problem-solving projects that typically connect youths with their civic mentors from local governments and public sector agencies.

School administrators have reported the positive effects your program has had on many facets of school life. In fact, the schools and parents are encouraging you to expand use of high school tutors and ensure that you continue to require ongoing academic skill building as a condition of civic "internship." Further,

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your staff has done its homework and has suggested that outreach to the middle school boys be accompanied by comprehensive educational assessment. The result of this assessment could aid your decisions about the adequacy of the present tutoring program for the needs of this particular population. If the present tutoring program is adequate for the needs of most of the boys, outreach and recruitment of those boys to this program should be a priority. Besides, your staff argues, if you are successful in the school and community domain, negative peer influences might well be diminished without specific intervention.

## Prioritize Risks and Assets Within Your Domain of Concentration

Whether you are one of several partners in a collaborative, an informal participant in a partnership, or going it alone, you will want to know as much as you can about the strengths and weaknesses of your particular population or geographic area of interest. The more carefully you have defined your population or place, the more likely you are to select the most appropriate program. You may need to rework your needs and assets assessment, utilizing CSAP's core measures and/or enlisting the help of experts as described in chapter 1.

Even if your program was pre-determined in a grant award, you should complete the individual level assessment, concentrating on the needs and assets within the domain in which you will be working. Otherwise, you will be handicapped when you come to the inevitable decisions about adaptation.

When you are satisfied with the quality and specificity of your individual level data for the defined population in the domain(s) you have chosen, prioritize the risks and assets. As you did when choosing your domain(s) of concentration, you should consider the relative importance among the risks and assets, your group's capacity, and where you think your efforts will be most successful. You are now ready to adjust your initial theory, or theories, of change to reflect your sharpened focus.

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## Examine Your Science-Based Options

Examine the science-based programs that are available for the domain you have chosen. You can locate these through a literature search that includes the following Web sites: www.preventiondss.org and www.modelprograms.samhsa.gov/. Different agencies have differing definitions for science-based programs. You will find CSAP's "Annual Report of Science-Based Prevention Programs" to be the most helpful in your selection effort. The report links model programs identified by CSAP to domains and to their risk and protective factors. CSAP continues to work with program developers to move promising programs into the effective and model categories. Therefore, the number of available model programs increases regularly.

Refer back to figure 3.3 to refresh your understanding of science-based programs. The "Comparison Matrix of Science-Based Prevention Programs" will also help you understand your science-based options. The matrix shows how CSAP and other agencies have rated programs. This matrix is also available from CSAP Web sites (see the resources section of this chapter for information on how to order or access it).

## Address Cultural Relevancy

Determine how the characteristics of the programs you are considering fit the individual needs and assets of your defined population or place, your adjusted theory of change, and your goals and objectives.

It is important that the program is culturally relevant for your purpose. A program designed to prevent alcohol and drug abuse for urban African-American youth may not be a good fit for Hispanic youth from migrant farm families.

When considering cultural relevance, take into account the community's values and existing practices and the culture and characteristics of the defined population. For example, well-baby and home visit support programs for teen mothers may not fit into a context in which young mothers are suspicious of social workers. Some young mothers may not allow social workers into their homes for fear that their babies will be removed. If you were considering this program, you would want to identify leaders within the culture you have defined to help you assess the probable reaction to such a program and recommend ways to increase its acceptance.

Here are some considerations for assessing the cultural fit of a program:

- Consider the cultural context and "readiness" of the defined population. Are they aware of and knowledgeable about the problem?
- Consider the values and traditions that affect how your defined group regards health promotion issues. What do they consider appropriate ways to communicate and provide helping services?
- Consider the extent to which the community is ready for the program (chapter 2). Are they willing to accept help and/or programs that ask for changes in their behavior, attitudes, and knowledge? What is their level of resiliency and their capability to make these changes?
- Determine whether the proposed program is appropriate given the cultural context and community readiness issues. What modifications/adaptations are needed? Consider the cost and feasibility of these adaptations/modifications (e.g., the cost of translating an entire curriculum into another language).



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- Consider how this program fits with other programs that are already being offered to the group you will be serving. Do similar programs exist? Are they complementary to yours? Do they work at cross-purposes?

## Explore Fidelity and Adaptation Needs and Balances

Communities differ, of course, and you may not find an exact match between a science-based program and your defined population's needs and/or characteristics. Finding an appropriate balance between *fidelity* (the rigor with which an intervention adheres to the developer's model) and *adaptation* (modification to a chosen intervention) is one of the most important challenges facing current prevention practice. Researchers and program developers are legitimately concerned that changes to a science-based program will dilute or even dissipate its effectiveness. Practitioners are concerned that a "one-size-fits-all" formula may not match actual community needs.

The following steps should guide your decision:

1. ***Identify and understand the theory base*** behind the program. Published literature on the program should provide a description of its theoretical underpinnings. If not, contact the program developer for this information.

   There may or may not be a logic model that describes, in linear fashion, how the program works. The theory and logic model are not in themselves core components of a program, but they can help identify what the core components are. This step also identifies core values or assumptions about the program that can be used to help persuade community stakeholders of the program's fit and importance for their environment.

2. ***Locate a core components analysis*** of the program. CSAP, through its National Center for the Advancement of Prevention, is conducting a large-scale core components analysis of its model programs, as part of developing and maintaining CSAP's National Registry of Effective Prevention Programs (NREPP). In the absence of a formal core components analysis for a program you are considering, you should contact the program developer for assistance. (For more information about the CSAP core components analysis, contact the Center for Substance Abuse Prevention or consult its online database, www.modelprograms.samhsa.gov/.)

3. ***Check your needs assessment to single out those characteristics of your defined population that are truly unique and assess whether adaptation is needed to address those unique characteristics.*** Even if you have been assigned a defined population or a program, you still should complete the







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needs assessment to ascertain unique characteristics or underlying conditions.This becomes a "must" if outcomes at any stage of program implementation are significantly less positive than expected.

4. ***Assess fidelity/adaptation concerns*** for the particular implementation site. This step means determining what adaptations may be necessary, given the community environment, political and funding circumstances, and other characteristics of the setting.

5. ***Consult as needed with the program developer*** to review the above steps and how they have shaped your plans for implementing the program. This may also include actual technical assistance from the developer or referral to peers who have implemented the program in somewhat similar settings.

6. ***Consult with the organization and/or community in which the implementation will take place.*** This is a process to bring fears and resistance to the surface, build support for the program, and obtain input on how to do the implementation successfully.

7. ***Develop an overall implementation plan*** based on this input. Include a strategy for achieving and measuring fidelity/adaptation balance for the program to be implemented, both at the initial implementation and over time. By addressing all of the complex stages of implementation, such a plan can increase the opportunities for making choices that shape a program, while maintaining fidelity. (See chapter 4 for more detail about the development of your implementation plan.)

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## Select the "Best-Fit" Science-Based Option

Three periods of development have affected the evolution of substance abuse prevention programs. The first period was driven by common sense, ideology, or intuition. Anumber of good ideas emerged from applying intuitive thinking to prevention; however, intuitive ideas alone do not always produce effective methods of prevention.

The second period involved the development of programs based on theory. Social psychologists, sociologists, developmental psychologists, and researchers grounded in public health issues drew on their respective disciplines to create a matrix of theoretical support for many programs, but the lion's share of the actual research was only indirectly related to substance abuse.

The third and current period is distinguished by a significant body of research. Much of what we now know about prevention is data-driven as well as theory-based. This means that the developers of many science-based programs are able to measure change as it applies to each of the components of their programs, as well as to demonstrate positive outcomes at program conclusion. The most rigorously evaluated programs among the science-based group have used control groups for comparisons and can attribute positive outcomes directly to the program or intervention.

In fact, those programs that have been most rigorously evaluated (effective and model programs as identified in CSAP's "Comparison Matrix of Science-Based Prevention Programs") can demonstrate positive outcomes that are achievable for different populations in different settings.

Selecting a program from among CSAP's identified effective and model programs provides you with two immediate advantages. First, if you have been thoughtful about linking the needs of your defined population or area of interest to the selection of an effective or model program, and you implement that program with fidelity to its core components, your ability to produce positive outcomes is almost assured. Second, in a related vein, your evaluation is much easier. The program developer has already used control groups to demonstrate that outcomes were directly related or attributed to the program and not to other conditions. Not only are you more likely to produce positive outcomes if your selection is from among CSAP's effective or model programs, but you need not worry about a control group to prove these outcomes.

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Note, however, that if you are part of a demonstration project or other type of special research, you might be compelled to use a control group or comparison group as part of your research design.

Keep in mind that all science-based programs, although theory-based and therefore related to a body of knowledge about substance abuse, have not been evaluated with equal rigor. This means that the more removed your selection is from a recognized effective or model program, the more rigorous you must be in evaluating your outcomes.

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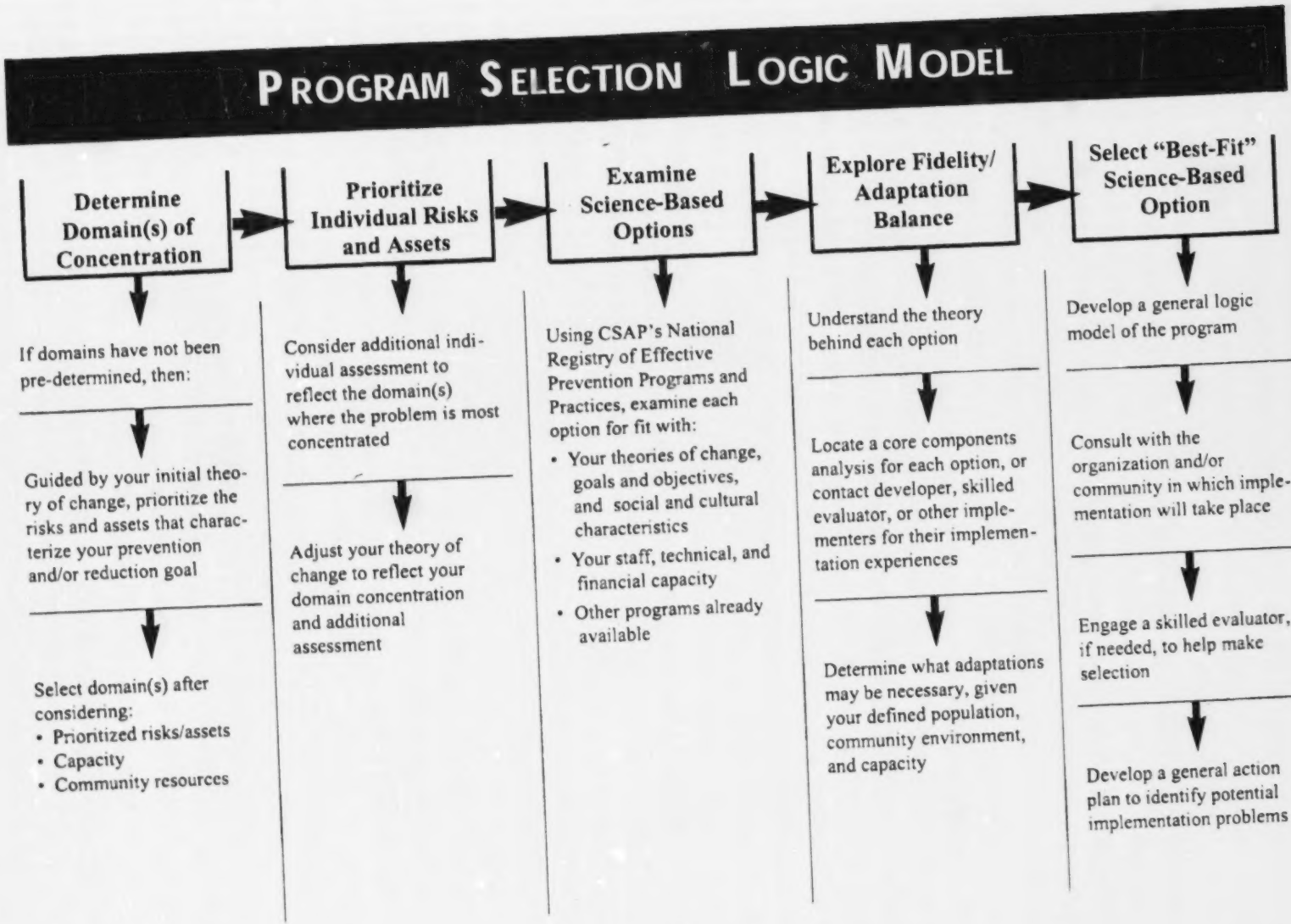
# In Summary

Fortunately, because of the growing body of research and evaluation in this field, we can now make more informed decisions about the critical step of selecting prevention programs. SAMHSA's Center for Substance Abuse Prevention (CSAP) has played a major role in recent years by identifying programs that have demonstrated successful outcomes. Your best solution most likely will be to choose programs that have been successfully replicated across venues and populations, demonstrating credibility, utility, and an ability to generalize.

Look again at the component logic model for this chapter (figure 3.2). This will remind you of the factors to consider when selecting a substance abuse prevention program. Now it is time to put all of this into practice. It is time for implementation and evaluation—the components covered in chapters 4 and 5.

# PROGRAM SELECTION LOGIC MODEL

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# CSAP Resources

CSAP-related Web sites:

Center for Substance Abuse Prevention/National Center for the Advancement of Prevention Decision Support System: www.preventiondss.org

Centers for the Application of Prevention Technologies: www.captUS.org

CSAP model programs: www.modelprograms.samhsa.gov/

A number of useful CSAP reports and publications are available through the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847. A full list is available at www.health.org/catalog/catalognew.asp?Topic=101.

*Annual report of science-based prevention programs*. Available: www.preventiondss.org

*Comparison matrix of science-based prevention programs*. Available: www.preventiondss.org

CSAP's Prevention Enhancement Protocol Systems (PEPS) Series systematically evaluates research and practice evidence on substance abuse prevention. Available: http://text.nlm.nih.gov/ftrs/dbaccess/csap

*Preventing problems related to alcohol availability: Environmental approaches reference guide.* (1999). Washington, DC: Substance Abuse and Mental Health Services Administration.

*Preventing substance abuse among children and adolescents: Family-centered approaches reference guide.* (1998). Washington, DC: Substance Abuse and Mental Health Services Administration.

*Reducing tobacco use among youth: Community-based approaches.* (1997). Washington, DC: Substance Abuse and Mental Health Services Administration.

# Resources and References

Brounstein, P.J., Zweig, J.M., & Gardner, S. (1998). *Science-based practices in substance abuse prevention: A guide* [Online working draft]. Available: www2.edc.org/capt/csap/

Mulhall, P., & Hays, C. (n.d.) *Levels of effectiveness of science-based prevention* [Online]. Retrieved Nov. 28, 2001: www.ccapt.org/levels.html

National Clearinghouse for Alcohol and Drug Information (NCADI): www.health.org

National Institute on Drug Abuse. *Preventing drug abuse among children and adolescents: A research-based guide* [Online]. Retrieved Nov. 28, 2001: www.nida.nih.gov/Prevention/Prevopen.html

Office of National Drug Control Policy, prevention resources: www.whitehousedrugpolicy.gov/prevent/programs.html

Centers for the Application of Prevention Technologies. *Science-based substance abuse prevention: A checklist of key characteristics of effective prevention interventions* [Online]. Retrieved Nov. 28, 2001: www2.edc.org/capt/science/framework/chklist.asp

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# Chapter 4

# Implement and Assess Programs

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# Introduction

Your work so far leads to the all-important process of implementing your selected program(s). You will see that implementation involves much more than simply carrying out the components of the program. It requires planning and documentation, evaluation, additional needs assessment, and adaptation, if necessary—and then more documentation.

Keep in mind that it is the extensive documentation during the implementation process that will provide the data needed to complete your evaluation. For example, if your immediate or intermediate outcomes are less than expected, the documentation process inherent in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION will enable you to go back and see where adjustments might be made so you can ensure your final outcomes.

This chapter shows how logic models and action plans can be used to facilitate this critical documentation process. The discussion continues in chapter 5 as the evaluation process is completed.

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## Important Terms

*Action Plan:* Translates the conceptual map represented by a logic model into an operational plan, detailing the key tasks that must be completed, including the measurement of outcomes.

*Adaptation:* Modification made to a chosen intervention (e.g., qualitative and/or quantitative changes to components); changes in audience, setting, and/or intensity of program delivery.

*Baseline Data:* The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

*Component Logic Model:* See Logic Model.

*Continuous Quality Improvement (CQI):* The systematic assessment and feedback of information about planning, implementation, and outcomes.

*Core Components:* Program elements that are demonstrably essential to achieving positive outcomes.

*Fidelity:* On a continuum of high to low, where high represents the closest adherence to the developer's design, the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a given organizational or community setting. In operational terms, the rigor with which an intervention adheres to the developer's model.

*Fidelity/Adaptation Balance:* A dynamic process that addresses both the need for fidelity to the original program model and the demonstrable need for local adaptation.

*Final Outcomes:* Outcomes inferred from the change as measured between the baseline descriptions of the general substance abuse problem—for the people, places, or policies that are the focus of the intervention—and the results, using the same measures, at the completion of the intervention.

*Goal:* The clearly stated, specific, measurable outcome(s) or change(s) that can be reasonably expected at the conclusion of a methodically selected intervention.



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*Immediate Outcome:* The initial change in a sequence of changes expected to occur as a result of implementation of a science-based program.

*Impact:* The long-term effect and/or influence of the intervention on the conditions described in baseline data.

*Implementation Plan*: As used in this Guide, a planning tool for the program manager. The plan need not be more detailed than that required by the program manager to establish initial direction and clarity of vision for the implementation group.

*Intermediate Outcomes:* In a sequence of changes expected to occur in a science-based program, the changes that are measured subsequent to immediate change, but prior to the final changes that are measured at program completion. Depending on the theory of change guiding the intervention, an intermediate outcome in one intervention may be an immediate or final outcome in another.

*Logic Model:* A graphic depiction of the components of a theory or program/initiative. In this Guide, two types of logic models are used:

*Program Logic Model*—Shows how all components of the program link together and lead to the achievement of program goals/outcomes.

*Component Logic Model*—Shows how the activities that make up a component of a prevention program link together to achieve immediate and intermediate outcomes (program objectives).

*Objectives:* As used in this Guide, measurable statements of the expected change in risks, assets, or other underlying conditions as expressed in the program's guiding theory of change.

*Outcomes:* The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, or longer term outcomes.

*Process Measures:* Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are *not* outcomes, because they describe events that are inputs to the delivery of an intervention.

*Program Logic Model:* See Logic Model.

## Logic Model Discussion for Program Implementation and Assessment

The figure below, 4.1, shows how the implementation component (the shaded column) fits into the overall framework for ACHIEVING OUTCOMES. The individual components of the implementation and assessment process make up a component logic model as depicted by figure 4.2.

Figure 4.1

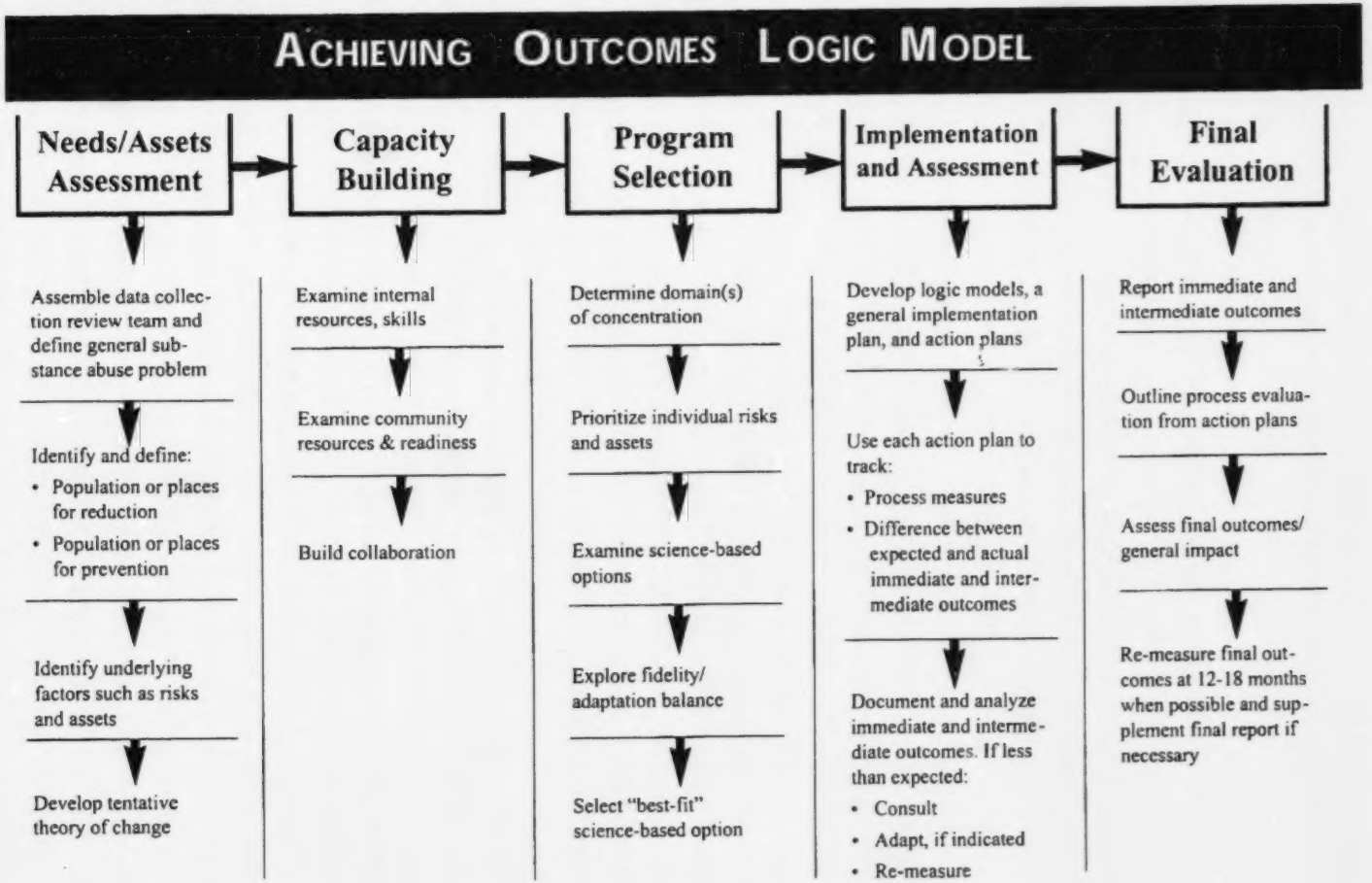




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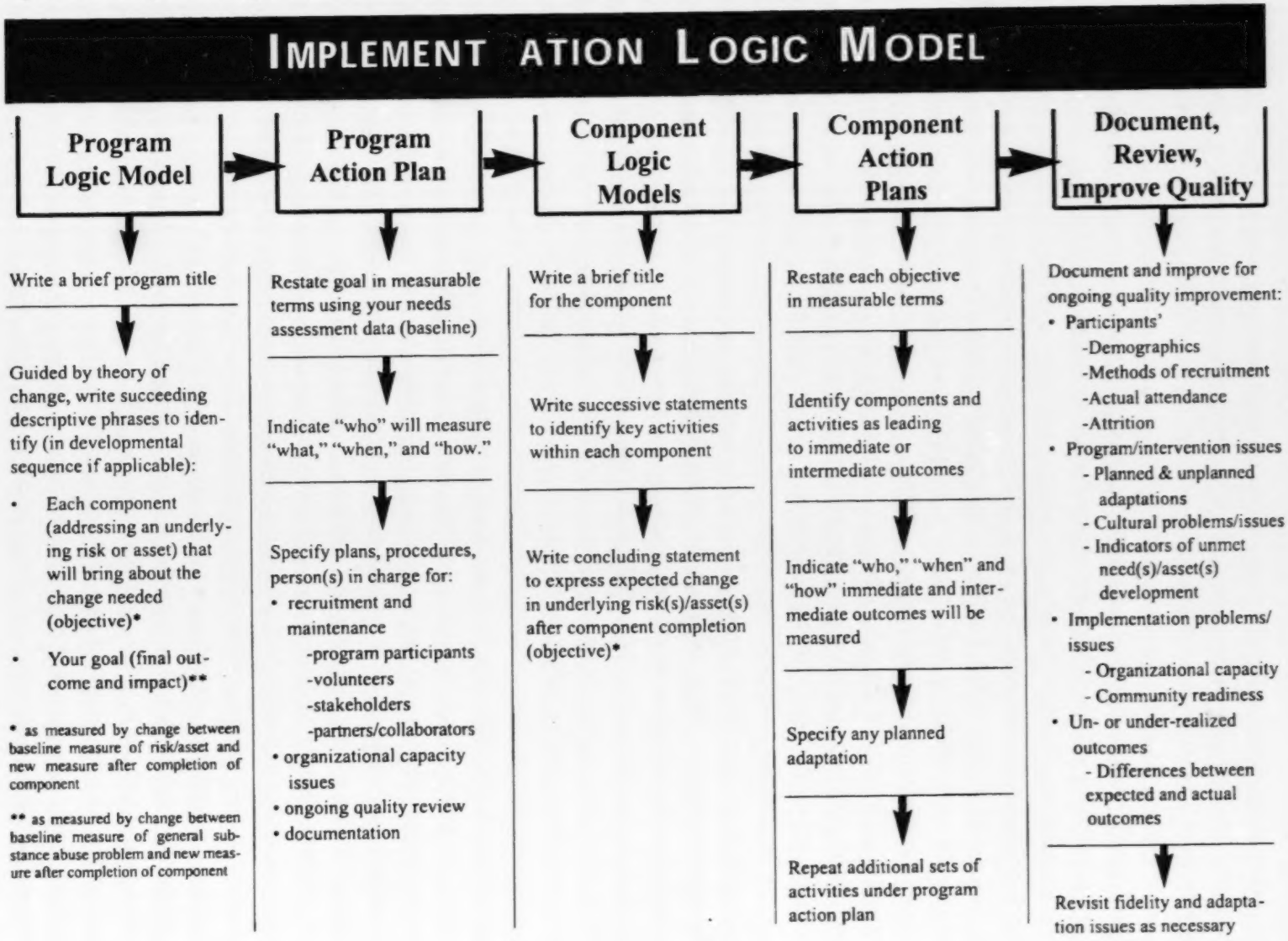
Figure 4.2 Component Logic Model for Program Implementation and Assessment



# Overview

## The Importance of Planning and Documentation

While implementation implies action, the implementation process actually begins with planning. Planning is pivotal to a successful outcome and, if done carefully, will make the evaluation tasks much easier. ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION is based on using logic models and action plans as the framework for this planning process.

Planning helps to increase the effectiveness of your effort—to focus energy, to ensure that staff and other stakeholders are working toward the same goals, and to assess and adjust programmatic direction, if needed. In short, planning is a structured effort to shape and guide your prevention initiative. With proper planning, you can avoid many of the problems that can undermine the success of the prevention effort.

The process described in ACHIEVING OUTCOMES uses three structural levels in substance abuse prevention planning:

- The *Program Logic Model*—a conceptual map that links individual program components to each other and to achievement of the *final outcome* (your goal).
- The *Component Logic Model*—a map of the activities that make up each of the components of a program. For example, a family strengthening program may consist of three different components. Each component may have its own group of activities. The implementation of each component can be tracked and, when completed, measured for *outcomes* (*immediate* and *intermediate outcomes*, or *objectives*). Outcomes are the measures of change in targeted attitudes, values, behaviors, or conditions from baseline to successive or subsequent points of measurement.
- The *Action Plan*—translates the conceptual map represented by a logic model into an operational plan. The action plan details the key tasks that must be completed to turn components and activities into reality. A good action plan details "who" in your organization will be doing

"what," "to whom," "for what purpose," "when," and "for how long." You should have an action plan for the implementation of each logic model.

Logic models bring into conceptual focus what must be done to achieve the desired outcomes. They define the pathway to final outcomes. Action plans are operational. In addition to documenting who, what, etc., they document immediate and intermediate outcomes. They call attention to the need for remedial action when immediate or intermediate outcomes are not achieved.

Together, logic models and action plans are helpful in producing process evaluations, because they document the unfolding of planned, unplanned, and alternative activities that have contributed to outcomes. Action plans, in particular, provide the outline for a process evaluation of the final report. They are a useful tool for managers in tracking outcomes and implementation issues. Action plans are also useful for facilitating timely communication among staff and stakeholders about both successes and areas of concern.

Documentation goes "hand-in-hand" with planning in the ACHIEVING OUTCOMES process. Documentation is critical to evaluation. Since evaluation is an ongoing process that actually begins with your needs and assets assessment, there is no way to separate it from the implementation phase. The documentation that you undertake while implementing your program (using your action plans) is essential to your final evaluation report. Chapter 4 works in concert with chapter 5. Discussion of some of the important concepts in your documentation process (e.g., *process measures*, immediate and intermediate outcomes, etc.) occurs in chapter 5. You should read chapter 5 and refer to it as necessary as you create and implement your logic models and action plans.

Since documentation is really a component of evaluation as well as implementation, be sure to involve your evaluation team as early in the process as possible. Evaluation works best as a team effort. One person heads the team and has primary responsibility for the project with assistance from other staff and volunteers. (You, the practitioner, need not be the team leader.) Together, your evaluation team does the following:

- Determines the design and measurement issues related to the evaluation;
- Develops the evaluation plan, outcome measures, and data collection instruments;

- Collects, analyzes, and interprets data; and
- Prepares the report on evaluation findings.

Just as you will do for your own program, this Guide has followed a program logic model (introduced in chapter 1). Each of the Guide's five chapters develops one of the components for achieving outcomes and presents it as a component logic model. Thus, five component logic models constitute the overall program logic model of ACHIEVING OUTCOMES:

1. Needs and assets assessment
2. Capacity building
3. Program selection
4. Implementation and assessment
5. Final evaluation

## Developing a Program Logic Model

A program logic model speaks directly to the achievement of outcomes. Your actual program components, or program elements, should correspond closely to your refined theory or theories of change.

Consider these questions as you formulate your program logic model:

- What are the components of the selected program that address each of the underlying risk factors you have listed for your population or area of interest?
- Is there a developmental sequence to these components and, if so, what is the proper sequence?
- What are the changes you can expect to bring about in the general substance abuse problem—your program *goal*—if your efforts are successful? (See the theory of change example in chapter 1 for a graphic depiction of these bulleted points.)

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To develop this logic model, first write a brief statement (a title, really) explaining the program. This is the first entry in your program logic model. Guided by the theory of change for your program, write successive statements to identify each component that addresses an underlying risk or asset that will help bring about the changes needed (the objectives) to achieve your goal (final outcomes)—the final box or circle (or whatever graphic element you are using) of your logic model.

If you are implementing a single program, and you have selected a model program, it is likely that the program developer has already created a logic model for you to consider. However, that logic model was not created using your defined population's unique risks and assets. You may still have to develop your own logic model to address not only those unique factors but also any adaptations you will be making to the program.

Even if you are not making adaptations, you will want to develop your own program logic model following the guidelines in this chapter. These guidelines are likely to be more detailed than the process followed by the developer. More important, the process of putting your concepts into a tangible form helps ensure that you and others have consensus.

The graphic format you choose to depict your logic model may look quite different from the boxes and arrows used in this Guide's examples of logic models. Any graphic format is fine, so long as it is clear, comprehensible, and usable by all.

## Developing Action Plans for the Program Logic Model

Action plans translate your conceptual map (the program and component logic models) into a practical operational plan. The action plan organizes your general implementation effort. This helps you direct and focus your efforts on your objectives and goals within your specified timeframe. Action plans also assign responsibility for the key activities identified in the logic models.

Like their companion logic models, action plans come in many forms and vary in their complexity. The format is not important as long as it can be clearly followed by others. While the level of detail will vary, generally you will keep the action plan for the program logic model relatively brief. Note that the term "implementation plan" is often used interchangeably with the term "action plan" at this level of planning. Later you will develop a separate action plan for each component in order to record more details.

Action plans are useful tools, especially for program directors. They have innumerable uses in organizing the effort, budgeting, managing the process, coordinating communications, documenting progress, and evaluating results. Here are some items to cover in your action plans:

- The successive tasks that must be completed by staff or partners before the program or component can begin;
- The assignment of authority and responsibility for task completion;
- Timelines associated with each task, including planned start, actual start, planned end, actual end;
- How and why adaptations are needed and to what effect;
- Who will be responsible for measuring, analyzing, and communicating with staff (and others as needed) relevant to differences between expected and actual change; and
- Who will be responsible for maintaining general documentation of the process overall.

Begin your general program action plan (implementation plan) by restating your goal in measurable terms, using needs assessment data (e.g., to prevent and/or to reduce _____ and/or

_____ by _____). Then decide, and indicate, who will handle the measurement, and when and how the measures will be taken. Finally, you need to specify the plans, procedures, and person(s) in charge for ongoing quality review (as detailed later in this chapter), organizational capacity issues (see chapter 2), and full documentation as documentation progresses.

You may wish to add detail to this program implementation plan, such as participant data (e.g., how many participants are expected to attend what/for how long). However, as noted above, you can save the detail for the component action plans. Either way, remember to keep the action plan current by documenting changes in assignments, timelines, and other operational matters that may be significant.

The more thoughtfully you develop and track activities, issues, and outcomes on your action plans, the easier it will be for you to pinpoint any problems, take corrective action, and produce the results you expect. In short, comprehensive action plans will minimize your evaluation tasks.

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## Developing Component Logic Models

Component logic models flow rationally from your program logic model. They provide the framework for the multiple components that make up the program. You develop a component logic model using the same process described for the program logic model.

Here are some questions to ask for each component:

- What are the key activities required throughout the component's scheduled cycle? Describe each briefly.
- What are the outcomes you expect after the completion of each component?
- Do your expected outcomes correspond closely to your refined theory, or theories, of change?

Review the figures 4.1 and 4.2 to see how the component logic model for the implementation stage relates to the overall program logic model for ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION. Also refer to the discussion of immediate and intermediate outcomes in chapter 5. These are the outcomes that you expect after completion of each program component and that are critical to achievement of your final goals.



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## Developing Component Action Plans

Like program action plans, component action plans delineate the who, what, where, when, how, and for how long of each component of your program. Unlike the overall program implementation plan, however, the component action plans will be quite detailed, sometimes extending for many pages. They may also include references to additional back-up documentation.

Here, for instance, you might list various activities involving sub-groups of your defined population. For each activity, indicate anticipated attendance, how you will recruit participants, details of where event(s) will take place, etc. Then, as each activity occurs, go back to the action plan and record actual attendance, anecdotal data on participant reactions, and comments from staff and others regarding expectations, disappointments, etc.

Begin each component action plan by restating the change you expect after completion of that component (e.g., "to increase academic core competencies for 12 of the 15 participants by at least one grade level within six months). Then, identify the components or activities that will enable you to meet each objective. Document on your action plan who will be responsible for each component and/or activity. Develop a very specific timeline. Keep track of participant attendance for each activity and make sure to note any unusual occurrence, positive or negative. Such information will be very helpful as you put together your process evaluation when questions arise about outcomes. Remember to indicate the immediate and intermediate outcomes that you expect, how they will be measured, and by whom.

After completion of the activities for each component, you will record the actual amount of change. This will be the change between the *baseline* measure and your subsequent measures of the underlying condition the component was designed to address. This is actually part of the evaluation process and may be one of your evaluator's tasks, depending on how your evaluation team is organized.

Should actual outcomes fall short of your expectations, examine your component action plans. Look for problems encountered during implementation. Review planned (or unplanned) adaptations. Consider cultural issues. A team meeting that includes the staff member responsible for the component in question may yield insight about why expectations were not met.

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A problem of unmet expectations may stem not from the implementation process itself but from the initial needs and assets assessment, which may have failed to dig deep enough into the needs of your defined population. The beauty of having detailed, thoroughly documented, action plans is that you not only see where you are going but where you have been. You can retrace your steps to explain why a component did or did not work as expected.

In the following example, the father was not ready for the family strengthening component being presented. Deeper analysis of his needs and assets clarified a need for training in basic parenting skills as a prerequisite for more advanced family strengthening concepts.

**Example: "Dealing with Unmet Outcome Expectations"**

*A facilitator in a family strengthening project reported to the project director that one of the youngsters had reported that his father had "thrown my brother out of the car." Fearing child abuse, the project director notified the facilitator for the parent group, only to learn that the father had, indeed, thrown the child out of the car—but not in such literal terms. The father, faced with a temper tantrum on the part of the seven-year-old, ordered the child out of the car and revoked his privilege to attend the event to which the family was headed. Clearly the father had assimilated some of the principles presented in the parenting class. But by leaving a seven-year-old unsupervised in the yard when the family left, the father put the program director and facilitators on notice that more basic parenting skills needed to be learned before the strategies of the family strengthening program could be successfully implemented. Additional assessment for the group in which the father was a participant revealed that many in the group could benefit from a precursor to the program that had been selected.*

## Maintaining Continuous Quality Control

Think of your logic models and the action plan for each component as "living" documents, to be reviewed regularly and modified when necessary. Your implementation team should routinely review the plans to see if you are on target or if mid-course adjustments are needed. The process that is popular in business circles, known as *Continuous Quality Improvement* (CQI), may help. Continuous Quality Improvement is the systematic assessment and feedback of evaluation information about planning, implementation, and outcomes. (Senge, 1994.)

Regular review of your program and component logic models and, especially, your action plans should be systemized within your organization. This is a crucial step in the success of your implementation, as well as your evaluation. Routine review enables you to do the following:

- Document program components that work well;
- Assess where improvements need to be made;
- Provide feedback to staff or others who can then implement the strategies more effectively;
- Make timely adjustments in activities and programming to better address the desired outcomes;
- Provide information for keeping others informed (including the media), if applicable; and
- Determine if enough resources have been leveraged. Where might you find more?

Here are some of the specific areas to document on your action plan as you monitor implementation:

- Participant information
  - —Demographics
  - —Methods of recruitment
  - —Actual attendance
  - —Attrition

- Program/Intervention issues
  - —Planned and unplanned adaptations
  - —Cultural problems/issues
  - —Indicators of unmet needs/assets development

- Implementation problems/issues
  - —Organizational capacity
  - —Community readiness

- Un- or under-realized outcomes
  - —The differences between expected and actual change (outcomes) as measured by the change between baseline and new measures at the completion of a component

Routine review of your action plans can prevent you from proceeding with a program that is not working. It provides feedback on day-to-day operations, which enables you to make timely adjustments in programming and activities to ensure a more direct path to the outcomes you seek.

Reviewing your action plans has another benefit. It involves the staff and volunteers in the decision-making process for improving the program. They receive feedback on the impact of what they are doing and can use this feedback to guide decisions. For instance, if feedback shows that participants in a training session are not grasping the concepts being taught, staff may decide to alter or intensify the teaching methods. Or, it may be that the teaching methods are not inadequate, but rather that the participants lack the "readiness" to grasp the concepts. With continuous review of your component logic models and action plans, you can identify barriers to success early, while there is still time to make adjustments.



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## Revisiting Fidelity and Adaptation Issues *During* Implementation

Science-based programs need to be followed as rigorously as possible. Real life tells us, however, that adaptations may be needed, as discussed in chapter 3. The adaptation discussed in that chapter occurred prior to implementation. You may also find that adaptation is necessary after your program is underway. Here are two real-life examples:

**Examples: "When Adaptation Might Be Needed"**

*A large organization with 30 years of experience in substance abuse prevention decided to implement a science-based program. After much research, it selected a program that had been successfully replicated many times and with many different defined populations. One of the major components of this program involved providing "in-home" therapeutic programs for all family members.*

*While all of the implementation steps were appropriately followed, the implementers began to notice that certain families were not achieving some of the intermediate outcomes. Further analysis uncovered that this happened with greater frequency among families of a particular culture, and that these families were often not home when the prevention specialist arrived to deliver the programs (even after confirming that the family members would be there). It was later learned that these families were uncomfortable when "outsiders" (even outsiders from their own culture) came into their home. Rather than address this issue directly, they expressed this discomfort by avoiding the "in-home" sessions.*

*Similarly, a community collaborative, whose mission was to develop strong families within their community, decided to implement a science-based program with a group of families identified as needing a range of family programs. The collaborative researched the options available and selected a science-based program that included multiple family components and programs.*

*This program had been successfully replicated in many locations with a broad range of defined populations. During implementation, however, the collaborative's staff noticed that certain predicted intermediate outcomes associated with a particular parenting skills component of this science-based program were not occurring. After additional needs assessment, they discovered that this particular defined population had generational histories of extremely poor parenting practices, and that the practices being taught in the science-based program assumed a more advanced foundation of parenting skills.*

Sometimes the need for adaptation does not become clear until the prevention initiative is well underway. Failure to achieve an immediate or intermediate outcome might be the first clue. Any time outcomes are not being achieved as expected, you must ask yourself why.

Use your action plan for other clues to why expectations are not being met. Is the data from your needs and assets assessment consistent with the science-based program you are implementing? Is the cultural context appropriate? Is the defined population sufficiently similar? Are the suggested activities relevant to your defined population? Perhaps your defined population simply is not ready for the planned program and a remedial or interim program must be implemented first.

Given the complexities in determining whether adaptations are needed during implementation, or whether the program or its specific components were simply not implemented properly, you may want to seek assistance from a skilled evaluator. With the evaluator's help and/or your evaluation team, review the following steps prior to making a decision to adapt:

- Revisit the theory base behind the program to be sure that it is consistent with the findings from your needs and assets assessment.
- Analyze the *core components* of the science-based program in conjunction with your action plan for each component to determine which one or more does not appear to be working.
- Check your needs assessment to single out those characteristics of your defined population that are truly unique and assess whether adaptation is needed to address those unique characteristics.
- Assess *fidelity* to ensure the core components were implemented as planned.

- Consult as needed with the program developer. Review the above steps and how they have shaped the plan for implementing the program in a particular setting. This may also include actual technical assistance from the developer, or referral to peers who have implemented the program in somewhat similar settings.
- Obtain feedback from the organization and/or community in which the implementation has taken place to help explain the outcomes you are getting.

Your analysis may take you back several steps to uncover the reasons for unsatisfactory results. That is why documentation is so important throughout this process of achieving outcomes. Knowing the steps you have taken will help you in repeating the steps that do work and not repeating (but correcting) the steps that do not.

Make sure that you document even your failures and how you corrected them on your action plan. Adjust your component logic model if necessary. Neither the logic model nor the action plan is a report card. They are important tools that will help you plan and also solve problems. You should not only record but also report on what you accomplish. Encourage implementers to document what does not work as well as what does. This is valuable information and can contribute greatly to the field, as well as to your own overall success.

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# In Summary

Using logic models and action plans may seem tedious at first, but once accustomed to the process, you will see what indispensable tools they can be. They will help keep your implementation on course toward positive outcomes. They will help you to know when adaptation is needed to meet your population's specific needs. They will facilitate the evaluation process and the reports needed to document your outcomes.

The power of logic models and action plans lies in the process they generate. They provide a focus for the collaboration of practitioners and communities in finding the best ways for achieving their goals and objectives.

These planning tools will also prove invaluable for building consensus. By facilitating analysis of why objectives have or have not been met, these tools help identify possible mid-course corrections and provide support when factors outside your control surface. When used to their best advantage, logic models and action plans serve as key building blocks for linking the community, program, budget, operations, and evaluation in a process that is results-oriented.

Reviewing the component logic model for this chapter (figure 4.2) will reinforce the importance of using these tools and documenting your implementation thoroughly. You will be glad for that documentation as you complete the evaluation process—the component described in chapter 5.



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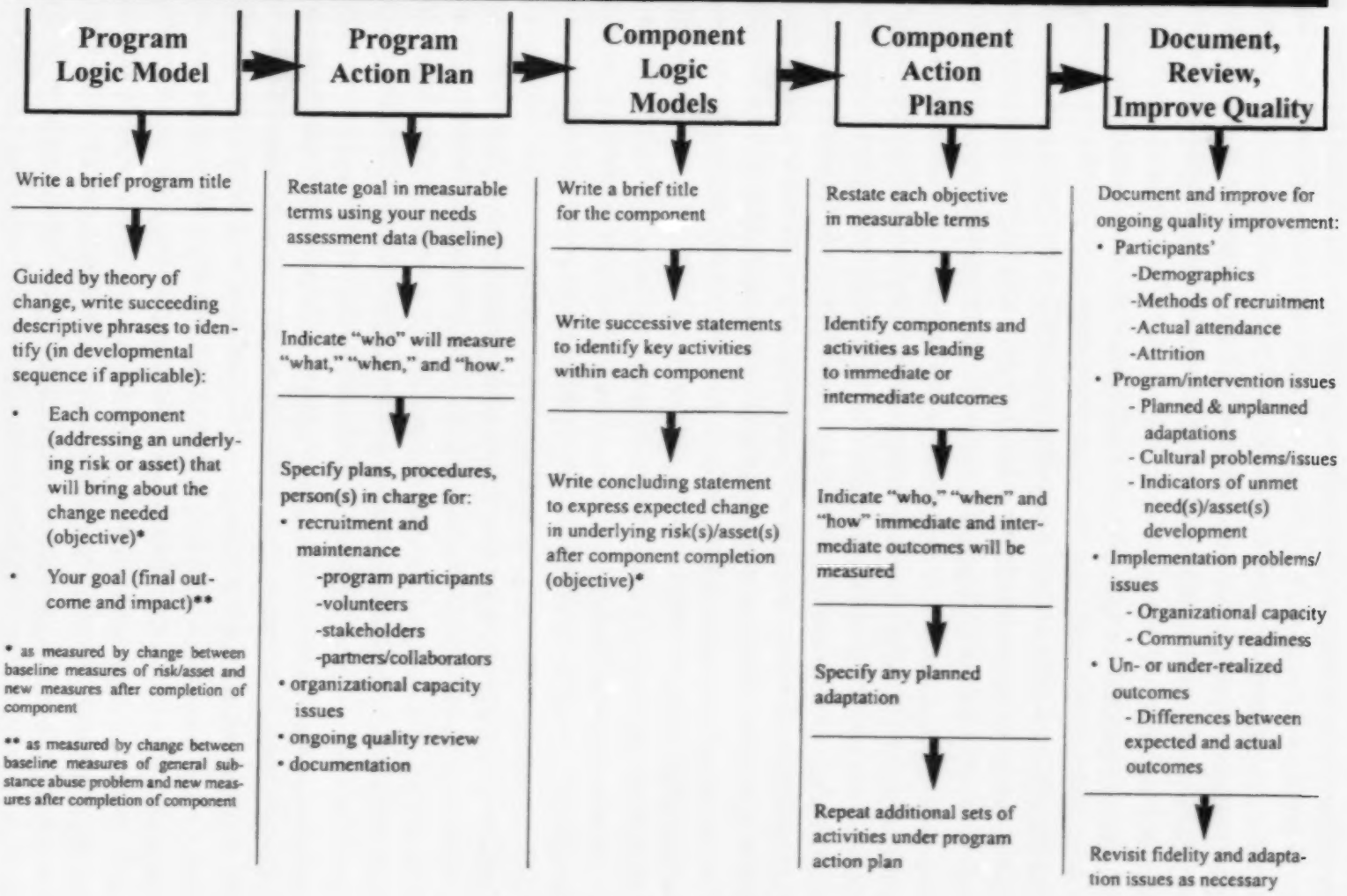
# IMPLEMENTATION LOGIC MODEL

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# Resources and References

CSAP-related Web sites:

Center for Substance Abuse Prevention/National Center for the Advancement of Prevention Decision Support System: www.preventiondss.org, specifically:

- How to implement and sustain prevention programs
- Lessons learned by the CSAP training system

Centers for the Application of Prevention Technologies: www.captUS.org

CSAP model programs: www.modelprograms.samhsa.gov/

Border CAPT. *Does It Fit (Adapting Models)* [Online]. Retrieved Nov. 28, 2001, at: www.bordercapt.org/english/aboutus/doesfit.htm

Center for Substance Abuse Prevention. (2002 Conference Edition). *Finding the balance: Program fidelity and adaptation in substance abuse prevention* [Online]. Available: www.preventiondss.org

Center for Substance Abuse Prevention. (1997). Guidelines and benchmarks for prevention programming (DHHS Publication No. 95-3033). Washington, DC: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

*Community Toolbox* is a Web site (http://ctb.lsi.ukans.edu/) created and maintained by the University of Kansas Work Group on Health Promotion and Community Development in Lawrence, KS, and AHEC/Community Partners in Amherst, MA. Selected units:

- Developing successful strategies: Planning to win, chapter 8, section 4
- Developing an action plan, part D, chapter 8, section 5
- Developing a plan for staff hiring and training, part D, chapter 10, section 1
- Hiring and training key staff of community organizations, part D, chapter 10, section 1

Northeast CAPT, presentation and training materials: www2.edc.org/capt/services/products/presentations

Senge, Peter. (1994). *The fifth discipline: The art and practice of the learning organization.* New York: Doubleday.

# Chapter 5

## Complete an Evaluation



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# Introduction

## Are we there yet?

The answer to that question can only be yes...and no. You have implemented your program, and documented the process on your action plans. You have measured and documented your immediate and intermediate outcomes and have used all this evaluation data for ongoing program improvement. In short, your evaluation has been a continuous process. Yet, you are not finished, because your final evaluation is the linchpin in ACHIEVING OUTCOMES.

Communities and funders today want results. They want *outcomes*. You want to demonstrate that your program (which in this Guide includes environmental interventions) works. You want to show that the changes taking place are meaningful and do justice to your efforts. If meaningful outcomes were elusive, you found out why. You have gone back to your needs and assets assessment, reviewed your underlying conditions, and/or examined readiness factors as they relate to your organization, defined population, or community. You have thought through the entire process quite logically, using your logic models and action plans to reexamine the steps you have taken. You have used your evaluation team according to their strengths and skills. What have you missed? Are there competing factors that diminish your ability to succeed?

The evaluation approach described here is called theory-based evaluation. It has been applied in the substance abuse area, in education, and in the evaluation of comprehensive community initiatives. It combines outcome data with an understanding of the process that leads to the achievement of those outcomes.

This type of evaluation starts with the premise that every initiative is based on a theory, or theories—some thought process about how and why it will work. The theory can be either explicit or implicit. The theory of how your initiative works helps you to identify your expected immediate and intermediate outcomes (objectives) that, if successfully achieved, will lead toward measurable changes in the

general substance abuse problem that was your initial concern—your goal. (See chapter 1 for more on developing your theory of change.)

The good news is that if you followed the process outlined in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION, you have already documented some measurable outcomes. You have empirical evidence that what you are doing is accomplishing what you intended, and you are well prepared to conclude your program and complete the last module in this process successfully.

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## Important Terms

*Baseline Data:* The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

*Final Outcomes:* Outcomes inferred from the change as measured between the baseline descriptions of the general substance abuse problem—for the people, places, or policies that are the focus of the intervention—and the results, using the same measures, at the completion of the intervention.

*Immediate Outcome:* The initial change in a sequence of changes expected to occur as a result of implementation of a science-based program.

*Impact:* The long-term effect and/or influence of the intervention on the conditions described in baseline data.

*Intermediate Outcomes:* In a sequence of changes expected to occur in a science-based program, the changes that are measured subsequent to immediate change, but prior to the final changes that are measured at program completion. Depending on the theory of change guiding the intervention, an intermediate outcome in one intervention may be an immediate or final outcome in another.

*Outcomes:* The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes.

*Process Measures:* Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are *not* outcomes, because they describe events that are inputs to the delivery of an intervention.

*Sustainability:* The likelihood that a program will continue over a period of time, especially after grant monies disappear.

## Logic Model Discussion for Evaluation

Figure 5.1, below, shows how chapter 5 of ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION fits into the overall program logic model. Chapter 5 is organized around activities and tasks that make up the component logic model for evaluation (figure 5.2).

Figure 5.1

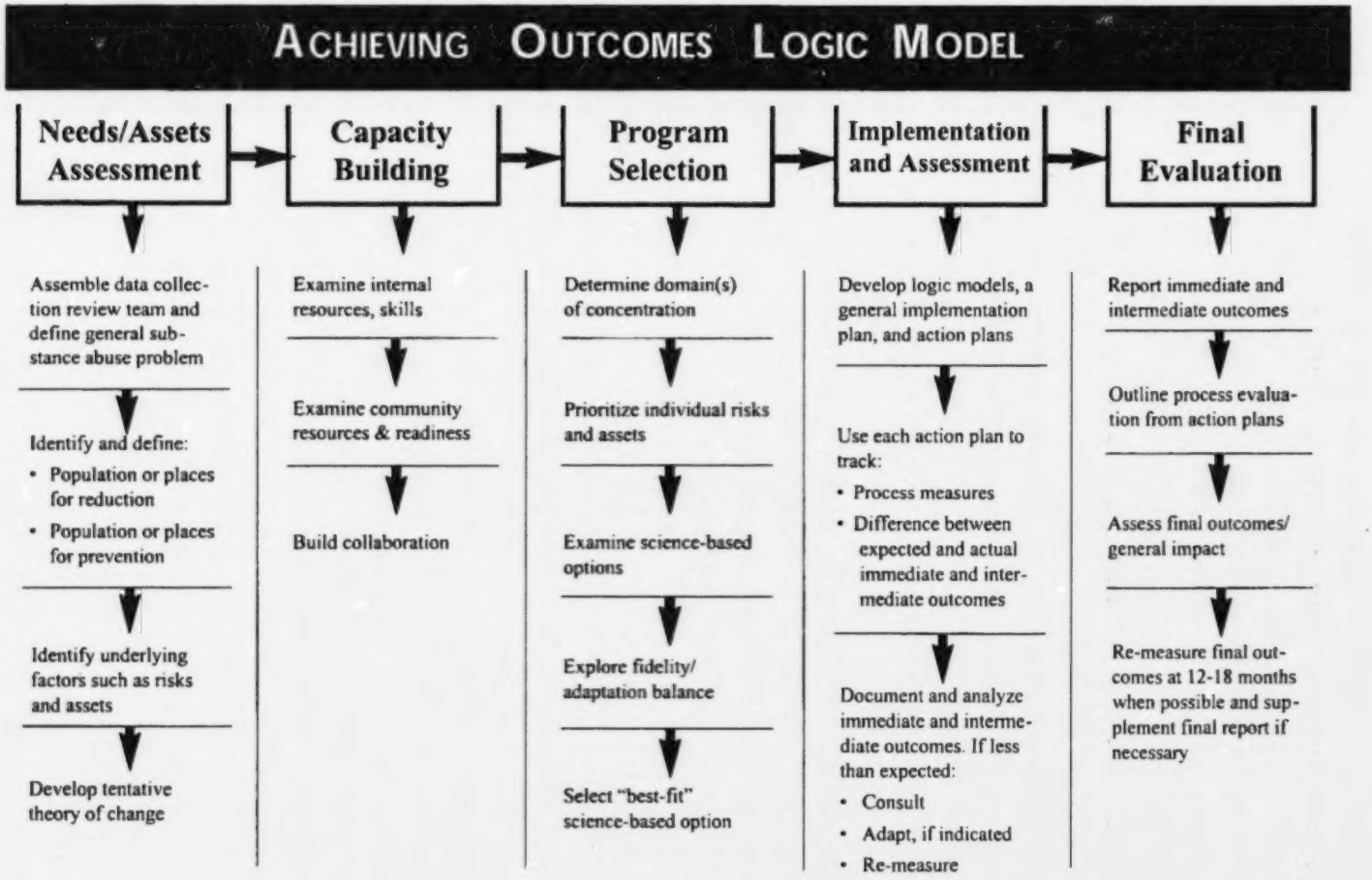


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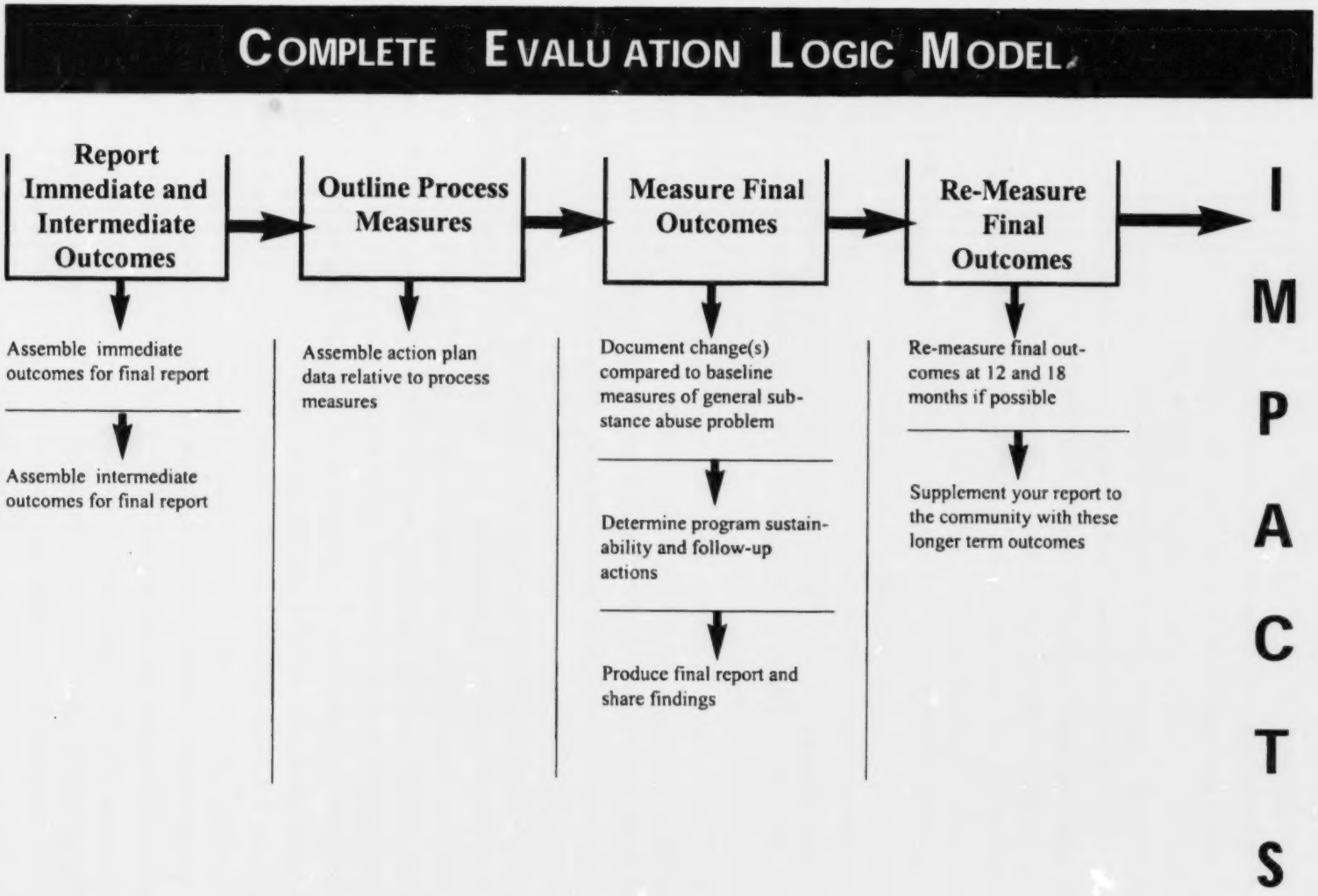
Figure 5.2 Complete Evaluation Component Logic Model



# Overview

## Evaluation: Well Worth the Effort

Carrying out a credible and useful evaluation is demanding. Local service providers and collaboratives generally do not employ in-house evaluation staff. Spending scarce resources to purchase evaluation services is a difficult choice. However, to the extent that you were able to use the outcomes-oriented process recommended in this Guide to engage in evaluation tasks, you have minimized both your reliance on and the cost of outside evaluation.

Your ability to shepherd a well-executed evaluation is not only beneficial to your program, organization, or collaborative, but also to the larger field of prevention practice. The prevention field needs to add to its database of promising approaches, innovations, and adaptations. This is done through the knowledge-based experiences of service providers and collaboratives. Each provider of prevention services who engages in systematic, theory-based evaluation contributes to the field as a whole.

ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION is an evaluation process from start to finish. Your completed logic models and accompanying action plans should be an excellent outline for your final evaluation report.

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# Why Evaluate?

## To Gain Insight

- Assess needs, desires, and assets of community members.
- Identify barriers to and facilitators of service use.
- Learn how to describe and measure program activities and effects.

## To Change Practice

- Refine plans for introducing a new service.
- Characterize the extent to which program plans were implemented.
- Enhance the cultural competence of your program.
- Verify that participants' rights are protected.
- Set priorities for staff training.
- Make mid-course adjustments to improve client flow.
- Improve the clarity of communication messages.
- Determine if customer satisfaction rates can be improved.
- Mobilize community support for the program.

## To Assess Effects

- Assess skills development by participants of the program.
- Compare changes in provider behavior over time.
- Compare costs with benefits.
- Find out which participants do well in the program.
- Decide where to allocate new resources.
- Document the level of success in accomplishing objectives.
- Demonstrate that accountability requirements are fulfilled.
- Aggregate information from several evaluations to estimate outcome effects for similar kinds of programs.
- Gather success stories.

## To Affect Participants

- Reinforce program messages.
- Stimulate dialogue and raise awareness regarding health issues.
- Broaden consensus among coalition members regarding program goals.
- Teach evaluation skills to staff and other stakeholders.
- Support organizational change and development.

From Center for Disease Control. *Framework for program evaluation in public health*, 1999.

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## Understanding the Levels of Outcomes

While each program is unique, its outcomes can be accounted for at three distinct stages:

- *Immediate Outcomes:* The initial changes in a sequence of changes expected to occur in a science-based program.
- *Intermediate Outcomes:* In a sequence of changes expected to occur in a science-based program, the changes that are measured subsequent to immediate change, but prior to the final changes that are measured at program completion. Depending on the theory of change guiding the intervention, an intermediate outcome in one intervention may be an immediate or final outcome in another.
- *Final Outcomes:* Outcomes inferred from the change as measured between the baseline descriptions of the general substance abuse problem—for the people, places, or policies that are the focus of the intervention—and the results, using the same measures, at the completion of the program.

The long-term effects and/or influence of the final outcomes on the conditions described in baseline data are known as *impacts*.



## Measuring Outcomes

### Immediate and Intermediate Outcomes

Immediate and intermediate outcomes are the changes between baseline, or measurement of your defined population's risks and assets, and the measurements repeated at completion of each of the components. Using the same instruments you used to measure the baseline for the underlying conditions for your defined population or area of interest, re-measure at the conclusion of the component that addresses the condition. Your action plans, which you developed during the implementation phase (see chapter 4), detailed your anticipated and actual immediate and intermediate outcomes.

If the outcomes were less than expected, you

- Reviewed your action plan for faulty implementation.
- Considered the need to undertake a deeper needs assessment to enrich your understanding of participant readiness.
- Consulted with the program developer or other experts regarding adaptation issues.

## Final Program Outcomes

The baseline measures that you established for the general substance abuse problem in your needs and assets assessment are measured again after all program activities are completed to ascertain your final and longer term outcomes.

- If possible, the same measures that were made at the completion of the program are repeated 12 and 18 months later to demonstrate sustainable outcomes, or longer term outcomes.
- **If you are part of a collaborative or a community partnership, your final outcomes are changes in the general substance abuse problem that caused your concern. These are broader in scope than the final outcomes of the individual collaborators. Your collaborators are "components" of your collaboration. Their final outcomes are your immediate or intermediate outcomes.**
- The change that you have measured in your general substance abuse problem is documented on your logic model and/or action plan.

## Process Evaluation

Process evaluation quantifies as well as qualitatively describes what you have done (the activity or program), to whom (how many in each group and how consistently), and for how long (hours, weeks, months, years). A process evaluation also describes how it was done and why it was done that way. Your component logic model maps—and your action plan tracks and documents—each aspect of the process, such as participant and implementer characteristics, attendance, implementation issues, etc.

The importance of process evaluation to the field is often underestimated. For example, program implementers report the number of youth, or families, or substance-abuse-addicted-parents they served without addressing one of the most important issues in program implementation and evaluation: participant attrition. Attendance history and the outreach methods used to attract and keep difficult-to-reach populations as active participants is a key issue for the prevention field.

Participation numbers alone may not show enough. For instance, a "community night out," co-sponsored by a collaborative, may attract hundreds of families. Beyond knowing that 400 people attended, would you not also want to know how the "community night out" fit into a broader coalition strategy and what type of follow-up activities might build upon that event?

This type of information adds to the knowledge base of program developers. It also helps you and other practitioners learn more about the programs you are considering. Think how other practitioners may benefit from your experience, especially when your collaborators document a difficulty with the implementation of a science-based program and the subsequent resolution of that difficulty. Tracking the causes of failures as well as successes helps increase the knowledge base for substance abuse prevention overall.

***Remember that your action plans are the vehicle to record all pertinent process information. They should be as detailed as necessary. If you are managing a collaborative, your evaluation will be greatly enhanced by the extent to which you can count on receiving process evaluations from each of your partners. As with immediate and intermediate outcomes, the process measures are recorded during the implementation phase.***

ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION is an evaluation process from start to finish. Your completed logic models and accompanying action plans should be an excellent outline for your final evaluation report.

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## Getting Help from Expert Evaluators

The resources (time, money, people) you have available will influence the extent of your involvement in developing and executing an evaluation plan. Pre-planning for this step should come as you develop your implementation plan and assemble your evaluation team. Balancing your expectations (and those of others) with what is realistic and manageable can be difficult. You will need to consider the following:

- Time. Whose time and how much is available to work on evaluation? What priority will evaluation have in your overall workload? Involving volunteers or participants is a way to spread the workload, but it may require additional time for preparation or training.
- Money. Some activities require financing. For example, what financial resources are available to print questionnaires, pay for postage, reimburse participants, analyze the data?
- Expertise. What outside expertise will you need to assist with evaluation? Do you have the necessary expertise to construct instruments or analyze the data? Or, are there experienced people with knowledge of your program who can train you in the skills needed? Would the involvement of an independent evaluator increase the evaluation's credibility?

Prevention practitioners usually have neither the inclination nor the time to produce a credible evaluation on their own. The assistance of an evaluator attuned to, and practiced in, the art and science of theory-based evaluation is essential. Sometimes the biggest challenge to getting useful evaluation results is finding an evaluator who understands your program and with whom you can work comfortably.

How do you find expert evaluators?

- Check with universities, research institutes, or consulting firms;
- Ask other prevention groups/organizations for recommendations;
- Consult with representatives from your State agency who are responsible for administering the Federal substance abuse block grant funds;
- Call the Center for the Application of Prevention Technologies (CAPT) in your region for suggestions, or consult the CSAP project officer assigned to your State.

Fortunately, if you have followed the process in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION, you have reduced the time and effort that must be spent by an evaluator to produce a credible evaluation. ACHIEVING OUTCOMES is data-driven and analysis-oriented. Since you have been a partner in the process, you have already identified and minimized the tasks requiring expertise that is beyond your organization's capacity. And, you have been using the ongoing evaluation process to keep program staff and key stakeholders engaged in the program's success, so that unwelcome surprises are unlikely.

## How Can You Be Sure of Your Conclusions?

*If you selected a science-based program and implemented it well, chances are you will have positive outcomes based on your expectations. But even science-based programs are subject to variable results, as suggested in the three scenarios below:*

### Scenario A

You were able to select a science-based program that matched your needs, and you implemented it with nearly 100 percent fidelity. Under such conditions, since your theory, or theories, of change fit the changes intended by the program design, you may have been able to duplicate the program's outcomes almost perfectly.

Because of this congruence between your theory-based objectives and those of the program(s) you selected, you have no reason to believe that extenuating circumstances or happenstance caused the outcomes. The program developer took care of that during his/her extensive pilot testing. It is likely that your objectives (intermediate outcomes) have been met, and you have every expectation that your long-term outcomes—reduction in substance abuse for this population—will also occur.

### Scenario B

You selected a science-based program but found it necessary to make significant adaptations, either directly or with the help of an outside expert. Even though your adaptations were done carefully and thoughtfully, with strict adherence to your underlying factors and theories of change, you cannot be absolutely sure that the outcomes you obtained resulted from the program and not from extenuating circumstances.

To ensure that the outcomes secured were a direct result of the program (with its adaptations), you introduced a comparison group, who received little or no services. At each point that you took measures of your defined group (with the exception of process measures), you took similar measures of your comparison group. Similar outcomes from both groups would lead you to believe that the outcomes are not solely a result of the program but of other factors as well. If you see the outcomes you desire from your defined population, but do not see these outcomes in the comparison group, you can be reasonably comfortable with attributing the outcomes to your program(s).

### Scenario C

You selected a science-based program and have made significant adaptations, but you do not have the capacity to set up a comparison or control group or cannot find one that has not already been exposed to significant substance abuse prevention programs. In this case, each time you measure a step in your intermediate outcomes or objectives, you might establish three separate measures of each change, taking care that each measure is indeed measuring the same thing.

Because of the complexity and time involved, this is a point where you might decide to seek outside assistance. When you have completed these three measures, you still cannot be absolutely sure that the outcomes are attributable to your program. However, the rigor you have exercised makes a compelling, if not an absolute, case.

*Even if you have followed the ACHIEVING OUTCOMES process rigorously, you will not be able to make a causal claim for your program unless you are in the Scenario A category and have implemented an effective or model program. However, you may have sufficient documentation to demonstrate that your findings provide compelling evidence of program success.*

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## Determining Sustainability

What happens after the program has been implemented and the follow-up activities described above have occurred? Consider the program's *sustainability*. Sustainability means that a program is likely to continue over a period of time, and there are resources to support it.

First, of course, you must determine if the program *should* be sustained. Changes in circumstances, staff, and community needs might suggest that this program is no longer a good "fit" for your defined population or broader community. Perhaps the desired outcomes were not achieved and a re-evaluation of the needs and assets assessment suggests that program selection was faulty. Perhaps there have been changes in your population, place, or policy of interest that reduce the need for the program or that call for a different intervention altogether.

Chances are, however, because of the care with which you selected the program, and the ongoing evaluative process that enabled you to make adjustments to achieve the desired outcomes, you will want to sustain a successful program. Continuing a successful program makes sense for several reasons:

- Ending a program that achieves positive results is counterproductive, if the problem for which it was chosen still exists.
- Creating a program requires significant start-up costs that can be amortized over future years if the program is continued.
- Implementing programs that are successful but not sustainable may jeopardize community support for future efforts.

Sharing the findings from your evaluation may ultimately be the most important thing you can do to make the case for sustaining a successful program.

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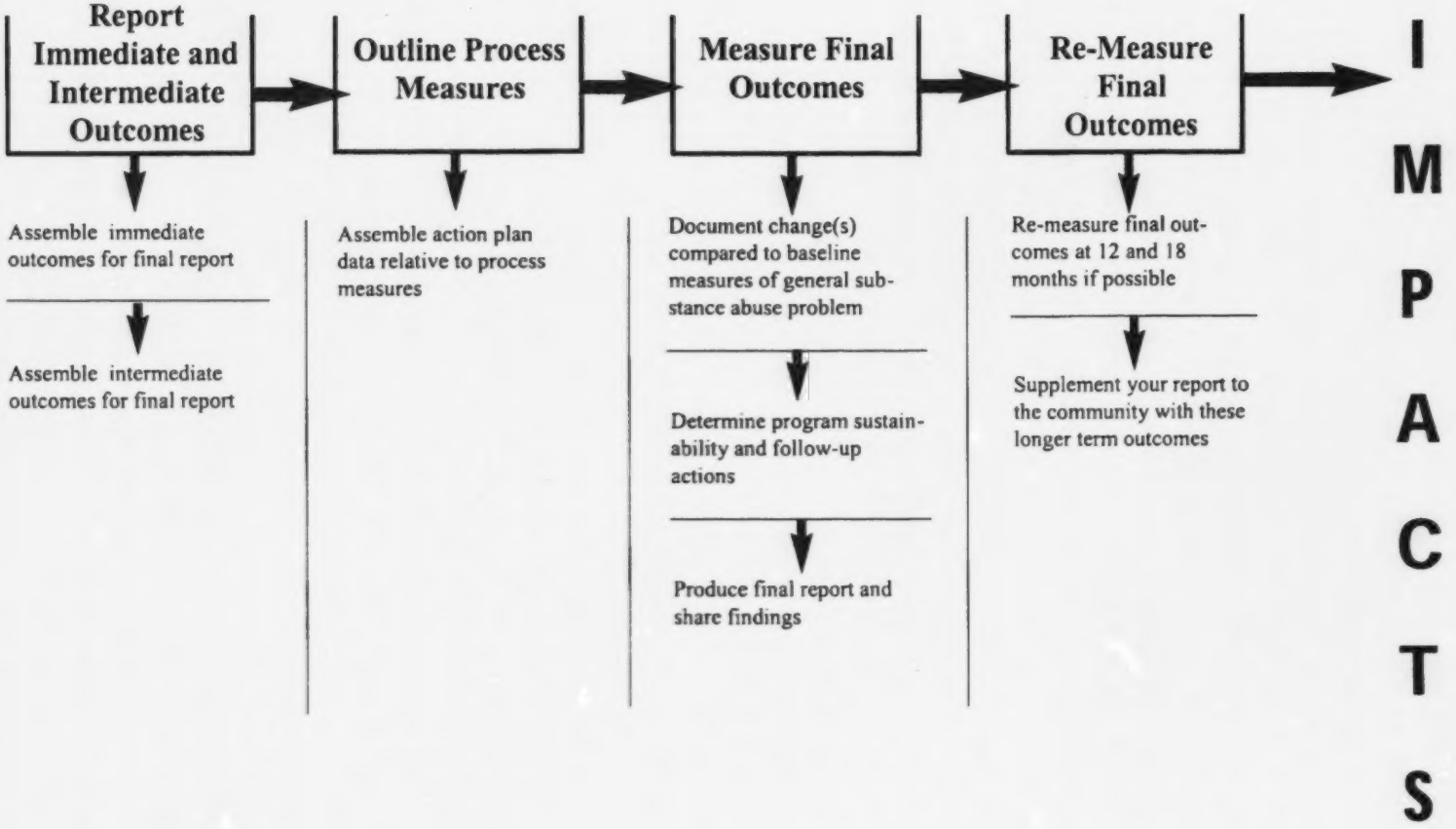
# In Summary

Communities and funders today want results. They want *outcomes*. And you want to demonstrate that your program works, that the changes taking place are meaningful and do justice to your efforts. The good news is that if you followed the steps outlined in ACHIEVING OUTCOMES: A PRACTITIONER'S GUIDE TO EFFECTIVE PREVENTION, you are likely to see measurable outcomes. You will have empirical evidence that what you are doing is accomplishing what you intended.

Look again at the logic model for the evaluation component of this process (figure 5.2). There are many potential benefits of employing the recommendations in this component. Evaluation will be an ongoing, dynamic, collaborative process. Evaluation expectations will be clear and appropriate. Information will steer future program development. Using a structure for collaborative evaluation, your group or collaborative can expect to strengthen its interventions and to amass solid evidence of its effectiveness—for your future programming and for the field as a whole.

In addition, by following this process, you will be able to ensure that your program is accountable to those it is serving—the community at large and those who are providing funding. The process of evaluating your program in a continuous fashion not only allows you to document measurable outcomes, but also to make necessary adjustments, direct the future of your program, and make it sustainable.

# COMPLETE EVALUATION LOGIC MODEL



# CSAP Resources

CSAP-related Web sites:

Center for Substance Abuse Prevention/National Center for the Advancement of Prevention Decision Support System: www.preventiondss.org

Centers for the Application of Prevention Technologies: www.captUS.org

CSAP model programs Web site, evaluation information: www.modelprograms.samhsa.gov/

A number of useful technical assistance bulletins are available through the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847. A full list is available at www.health.org/catalog/catalognew.asp?Topic=101. Of particular interest:

*A guide for evaluating prevention effectiveness*

*Cultural competence series for evaluators*

*Guide to risk factor and outcome instruments for youth substance abuse prevention program evaluations*

*Measurements in prevention: A manual on selecting and using instruments to evaluate prevention programs*

# Resources and References


Annie E. Casey Foundation. (1995). *Getting smart, getting real: Using research and evaluation information to improve programs and policies* [Online report]. Available: www.aecf.org/publications/getsmart/aecget.htm

Bureau of Justice Assistance Evaluation Web site is designed to provide a variety of resources for evaluating criminal justice programs: www.bja.evaluationwebsite.org/

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*Community Toolbox*, specifically: Our evaluation model: Evaluating comprehensive community initiatives: http://ctb.lsi.ukans.edu/tools/EN/section_1007.htm

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# Glossary of Important Terms

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# Glossary of Important Terms

**OUTCOMES :** The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes.

**PROGRAM :** A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population.

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| Action Plan | Translates the conceptual map represented by a logic model into an operational plan, detailing the key tasks that must be completed, including the measurement of outcomes. In this Guide, the action plan details (a) how resources are used to get the planned work done; (b) whether or not the work was completed as planned; and (c) the result of the work (e.g., outreach brought in 40 participants) or the outcome at the completion of a component (e.g., 75 percent of the participants who completed at least 20 hours express significantly more negative feelings about recreational substance abuse than they expressed at baseline). |
| Adaptation | Modification made to a chosen intervention (e.g., qualitative and/or quantitative changes to components); changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when (a) underlying program theory is understood; (b) core program components have been identified; and (c) both the community and needs of the population of interest have been carefully defined. Research also indicates that success improves when adaptations are handled as additions to, rather than deletions of, program components. |
| Age of Onset | In substance abuse prevention, the age of first use. |

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| Anecdotal Evidence | Information derived from a subjective report, observation, or example that may or may not be reliable but cannot be considered scientifically valid or representative of a larger group or of conditions in another location. |
| Archival Data | Relative to the collection of data for needs assessment purposes, information that is collected and stored on a periodic basis. For example, most public agencies collect data that can be used directly or indirectly for an overall picture of substance use or abuse within the geographic area served by that agency (e.g., emergency room statistics, school surveys on substance abuse trends, crime reports). Once collected, the data can be cross-referenced in various combinations to identify individuals, groups, and geographic areas that are most appropriate for prevention or reduction purposes. |
| Assets | In social development theory, the individual skills and strengths that can protect against substance abuse. In this Guide, the term is also used to describe social, fiscal, recreational, and other community support and resources that can be marshaled in the interest of prevention. See also, Protective Factors. |
| Assets Assessment | As described in this Guide, the process of identifying personal and community resources that build resistance to substance abuse. |
| Baseline Data | The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention. |
| Bicultural Stress | The difficulty or strain associated with living in a culture that is different from one's own. |
| Buffer | In this Guide, a descriptive term for an asset, protective factor, condition, behavior, or attitude that serves as a shield or an insulator against a harmful condition. |
| Capacity | In this Guide, the various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions. |
| Collaboration | The process by which people/organizations work together to accomplish a common mission. |
| Community Awareness | In this Guide, a perception or recognition on the part of the community that there is a substance abuse problem. The level of this awareness can change over time. |

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| Community Readiness | In this Guide, the community's awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives. |
| Component Logic Model | See Logic Model. |
| Conceptual Soundness | In this Guide, refers to the linkage of underlying factors and theory to interventions and outcomes in a logical way. The extent of conceptual soundness is based on existing theory or research underlying the model of change that supports the intervention. |
| Continuous Quality Improvement (CQI) | The systematic assessment and feedback of information about planning, implementation, and outcomes. |
| Core Components | Program elements that are demonstrably essential to achieving positive outcomes. |
| Credibility of Findings | Represents a continuum that is at its highest when the quality of implementation and evaluation are both high. |
| CSAP's Core Measures | As used in CSAP terminology, a compendium of data collection instruments that measure those underlying conditions—risks, assets, attitudes, and behaviors of different populations—related to the prevention and/or reduction of substance abuse. |
| Cultural Competence | The capacity of individuals to incorporate ethnic/cultural considerations into all aspects of their work relative to substance abuse prevention and reduction. Cultural competence is maximized with implementer/client involvement in all phases of the implementation process, as well as in the interpretation of outcomes. |
| Cultural Sensitivity | The ability to recognize and demonstrate an understanding of cultural differences. |
| Data Analysis | In this Guide, the use of statistical and/or classification procedures that provide at least a preliminary understanding of the phenomena in question. In general terms, the assessment, interpretation, and/or appraisal of systematically collected information. |

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| Data Driven | A process whereby decisions are informed by and tested against systematically gathered and analyzed information. |
| Defined Population | In this Guide, the people whose attitudes, knowledge, skills, risks/assets, and behaviors are to be strengthened or changed. Also known in the field as the target group, the population of interest, or the target population/group. |
| Domain | Sphere of activity or affiliation within which people live, work, and socialize (e.g., self, peer, school, workplace, community, society). |
| Effect | A result, impact, or outcome. |
| Effective Program | In CSAP's terminology, an intervention that builds upon established theory, comprises elements and activities grounded in that theory, demonstrates practical utility for the prevention field, has been well implemented and well evaluated, and has produced a consistent pattern of positive outcomes. |
| Environmental Analysis | An assessment of the formal and informal policies and the social, physical, or cultural conditions affecting an individual or a community. |
| Evaluation Instruments | Specially designed data collection tools (e.g., questionnaires, survey instruments, structured observation guides) to obtain measurably reliable responses from individuals or groups pertaining to their attitudes, abilities, beliefs, or behaviors. |
| Fidelity | On a continuum of high to low, where high represents the closest adherence to the developer's design, the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a given organizational or community setting. In operational terms, the rigor with which an intervention adheres to the developer's model. |
| Fidelity/Adaptation Balance | A dynamic process that addresses both the need for fidelity to the original program model and the demonstrable need for local adaptation. |

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| Final Outcomes | Outcomes inferred from the change as measured between the baseline descriptions of the general substance abuse problem—for the people, places, or policies that are the focus of the intervention—and the results, using the same measures, at the completion of the intervention. |
| Focus Group | A representative group of people questioned together about their opinions, usually in a controlled setting. Focus groups are widely used as a method of gathering qualitative data. When created and implemented skillfully, they can bring an evaluator or evaluation team "inside" the issue of interest. |
| Generalizability | As used in this Guide, the extent to which the positive or negative findings produced by specific interventions under specified conditions can be duplicated in future efforts in different settings with different populations. |
| Goal | The clearly stated, specific, measurable outcome(s) or change(s) that can be reasonably expected at the conclusion of a methodically selected intervention. |
| Human Capacity/Resources | The collective knowledge, attitudes, motivation, and skills of the program implementers and other stakeholders. |
| Immediate Outcome | The initial change in a sequence of changes expected to occur as a result of implementation of a science-based program. |
| Impact | The long-term effect and/or influence of the intervention on the conditions described in baseline data. |
| Implementation Plan | As used in this Guide, a planning tool for the program manager. Developing such a plan enables the program manager to gain control by identifying the functional and specialized requirements of the carefully chosen intervention; to pull together the team that must work together to produce a whole—without gaps, friction, or unnecessary duplication of effort—and to identify performance expectations for each of the program components. The plan need not be more detailed than that required by the program manager to establish initial direction and clarity of vision for the implementation group. |

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| Incidence | A measure of the number of people (often in a defined population) who have initiated a behavior—in this case drug, alcohol, or tobacco use—during a specific period of time. The measure's special value is that it identifies new users to be compared to the number of new users historically, over comparable periods of time. |
| Indicator | A substitute measure for a concept that is not directly observable or measurable (e.g., prejudice, substance abuse). For example, an indicator of "substance abuse" could be "rate of emergency room admissions for drug overdose." Because of the imperfect fit between indicators and concepts, it is better to rely on several indicators rather than just one when measuring this type of concept. |
| Intermediate Outcomes | In a sequence of changes expected to occur in a science-based program, the changes that are measured subsequent to immediate change, but prior to the final changes that are measured at program completion. Depending on the theory of change guiding the intervention, an intermediate outcome in one intervention may be an immediate or final outcome in another. See Outcomes. |
| Lead Agency | The organization responsible for fiscal management and performance accountability. |
| Logic Model | A graphic depiction of the components of a theory or program/initiative. In this Guide, two types of logic models are used:<br><br>Program Logic Model—Shows how all components of the program link together and lead to the achievement of program goals/outcomes.<br><br>Component Logic Model—Shows how the activities that make up a component of a prevention program link together to achieve immediate and intermediate outcomes (program objectives). |
| Mobilization | As used in this Guide, the process of bringing together and putting into action volunteers, community stakeholders, staff, and/or other resources in support of one or more prevention initiatives. |
| Model Program | In CSAP's terminology, model programs have all of the positive characteristics of effective programs with the added benefit that program developers have agreed to participate in CSAP-sponsored training, technical assistance, and dissemination efforts. See Effective Program. |

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| National Survey | Most often, a data collection effort conducted among a specially selected sample of people, who are, at the least, statistically representative of a larger population or group. National surveys are generally free from regional biases because they cover every region of the country and are typically sponsored by a Federal agency interested in determining national trends on a selected issue. |
| Objectives | As used in this Guide, measurable statements of the expected change in risks, assets, or other underlying conditions as expressed in the program's guiding theory of change. |
| Objectivity | As used in this Guide, refers to the expectation that data collection, analysis, and interpretation will adhere to standards of research that protect outcomes or results from the influence of personal preferences or loyalties. |
| Outcomes | The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes. For example, changes in attitudes and values about substance abuse may be the final outcome of an informational intervention. However, changes in attitudes and values may be the immediate outcome of a parenting program that builds on those changes to bring about changes in communication patterns and other skills (intermediate outcomes). Changes in communication patterns would, in turn, strengthen middle school children's resistance to negative peer pressure (intermediate outcome), resulting in a delay in the onset of substance use (final outcome). |
| Practical Significance | Meaningful and relevant information or results that have utility for the field. Some results may have statistical significance but little utility (e.g., statistically, left handed people use more drugs than right handed people). Evaluators often struggle with how to present findings and/or outcomes so they are relevant, meaningful, and useful to the practitioner and decisionmakers. |
| Precipitating Factors | Conditions or events that prompt or facilitate another condition or event. |
| Prevalence | As used in this Guide, numbers of people using or abusing substances during a specified period, usually per year. |
| Process Measures | Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are *not* outcomes, because they describe events that are inputs to the delivery of an intervention. |

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| Program | A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population. |
| Program Logic Model | See Logic Model. |
| Promising Program | In CSAP's terminology, the first of three categories of science-based programs on a continuum that concludes with model programs. Promising programs are those that have been reasonably well evaluated, but the positive findings are not yet consistent enough, or the evaluation not yet rigorous enough, for the program to qualify as an effective program. CSAP's hope is that promising programs, through additional refinement and evaluation, will evolve into effective and model programs. |
| Protective Factors | Conditions that build resilience to substance abuse and can serve to buffer the negative effects of risks. Also referred to as assets. |
| Proxy Measures | In this Guide, data that can be used as an indicator—an indirect measure of substance use or abuse. In general, multiple indirect measures (proxies) are more reliable than a single proxy. An individual can also serve as a proxy. For example, a parent can serve as a proxy for his or her child; a community stakeholder can serve as the spokesperson/proxy for a group unwilling to talk with an interviewer. |
| Reliability | The consistency of a measurement, measurement instrument, form, or observation over time. The consistency of results (similar results over time) with similar populations, or under similar conditions, confirms the reliability of a measure. When desirable outcomes elude precise measurement, the reliability of descriptive information is key. The reliability of descriptive data (usually qualitative) is enhanced by the rigor and integrity of the techniques used for data gathering and analysis, the extent to which there are several different data sources for each of the phenomenon being described, the objectivity of the person or team reporting, and the logic and credibility of the theory behind the intervention. |
| Resilience | Refers to the ability of an individual to cope with or overcome the negative effects of risk factors or to "bounce back" from a problem. |
| Risk Factors | Conditions for a group, individual, or defined geographic area that increase the likelihood of a substance use/abuse problem occurring. |

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| School Survey | A process, most often using a specially designed instrument, to collect information relevant to school administration, student attitudes and behaviors, and/or student performance. |
| Science-Based Program | A program that is theory-driven, has activities related to theory, and has been reasonably well implemented and well evaluated. |
| Social Indicator | A measure of a social issue that has been tracked over time (e.g., family and community income, educational attainment, health status, community recreation facilities, per pupil expenditures, etc.) and can be used as a proxy measure. Social indicators are often used to document levels of community and group risk and to serve as proxies for the existence of social problems, such as substance use/abuse. |
| Stakeholders | As used in this Guide, all members of the community who have a vested interest (a stake) in the activities or outcomes of a substance abuse intervention. |
| Statistical Significance | A term that defines the probability that an observed outcome can occur by chance alone. The smaller the chance (probability), the more likely the effect obtained can be attributed to the intervention. Statistical significance need not translate directly to practical significance. |
| Strategic Planning | A disciplined and focused effort to produce decisions and activities to guide the successful implementation of an intervention. |
| Subjectivity | Said to exist when the phenomena of interest is described, discussed, or interpreted in personal terms, related to one's attitudes, beliefs, or opinions. |
| Survey Data | Information collected from specially designed instruments that provide data about the feelings, attitudes, and/or behaviors of individuals. |
| Sustainability | The likelihood that a program will continue over a period of time, especially after grant monies disappear. |
| Technical Capacity | Specialized skills or specific expertise required for program implementation and sustainability. |

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| Theory of Change | As used in this Guide, a set of assumptions (also called hypotheses) about how and why desired change is most likely to occur as a result of a program. Typically, the theory of change is based on past research or existing theories of human behavior and development. |
| Underlying Factors | Behaviors, attitudes, conditions, or events that cause, influence, or predispose an individual to resist or become involved in problem behavior, in this case, substance abuse. See also, Assets and Risk Factors. |
| Validity | The extent to which a measure of a particular construct/concept actually measures what it purports to measure (e.g., Is "years of schooling" a valid measure of education?). |

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2002 Conference Edition

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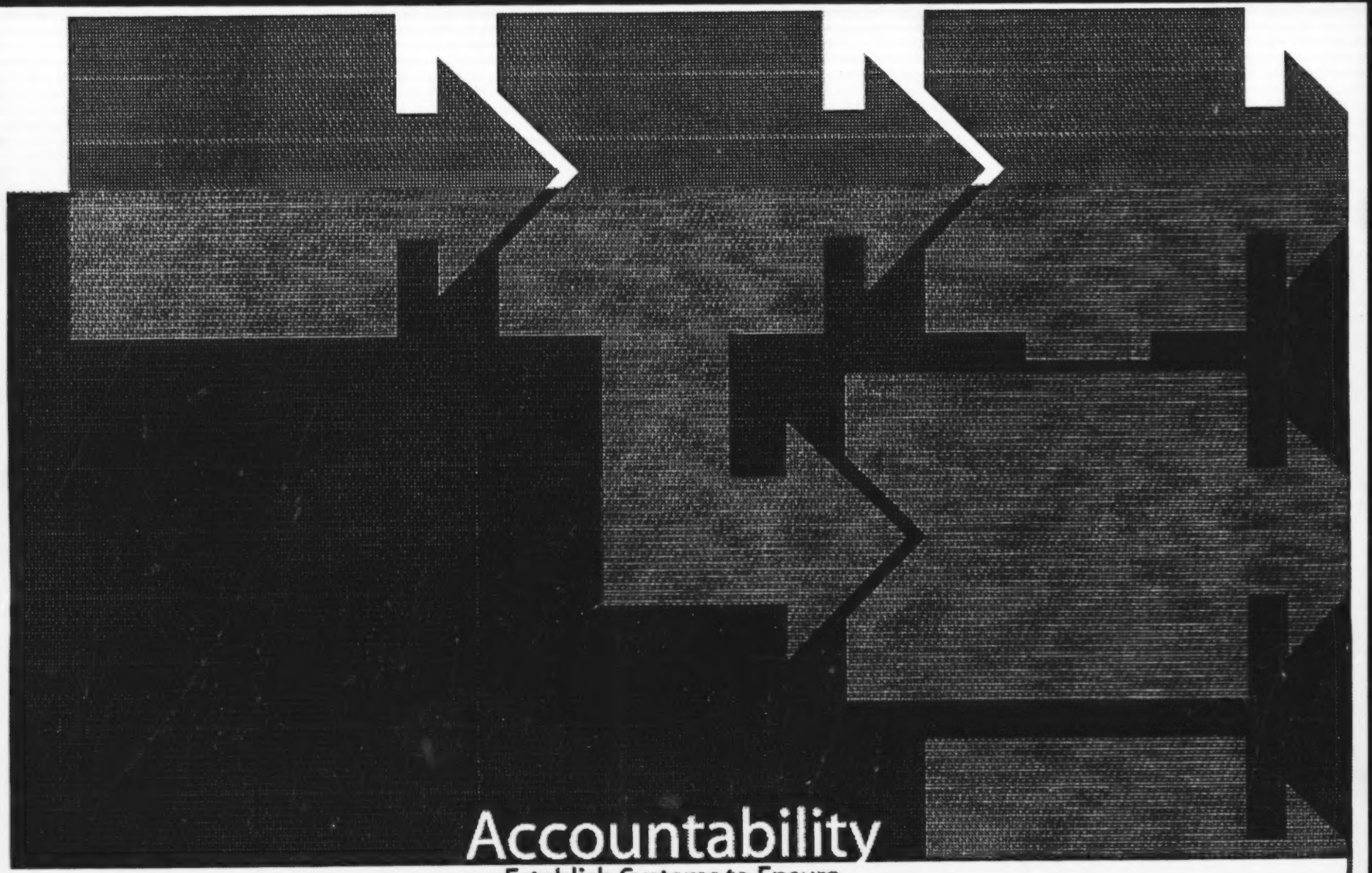


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